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ABSTRACT

Although considerable effort is being expended on school-based HIV prevention education, few data are available to suggest whether these programs are successful. Developed to help educators evaluate the quality of their HIV prevention programs, this handbook includes information on evaluation designs and measurement tools for collecting data on the basic program components of policy development, curriculum design, teacher training, and student outcomes. The handbook comprises eight interrelated booklets. The first booklet presents five key program-evaluation guidelines, while the second focuses on developing and revising HIV policies. The third and fourth booklets present guidelines for appraising HIV curricula and staff development programs, respectively. The fifth and sixth booklets describe assessment instruments for measuring student outcomes for grades 5-7 and 7-12, respectively, focusing on HIV-related knowledge, attitudes, and behaviors. The seventh booklet offers seven guidelines for selecting and working with an external evaluator to appraise an HIV education program. The last booklet presents five guidelines to assist in reporting results of evaluation studies related to HIV education. Three sample evaluation reports are included to illustrate use of the guidelines. (MLH)

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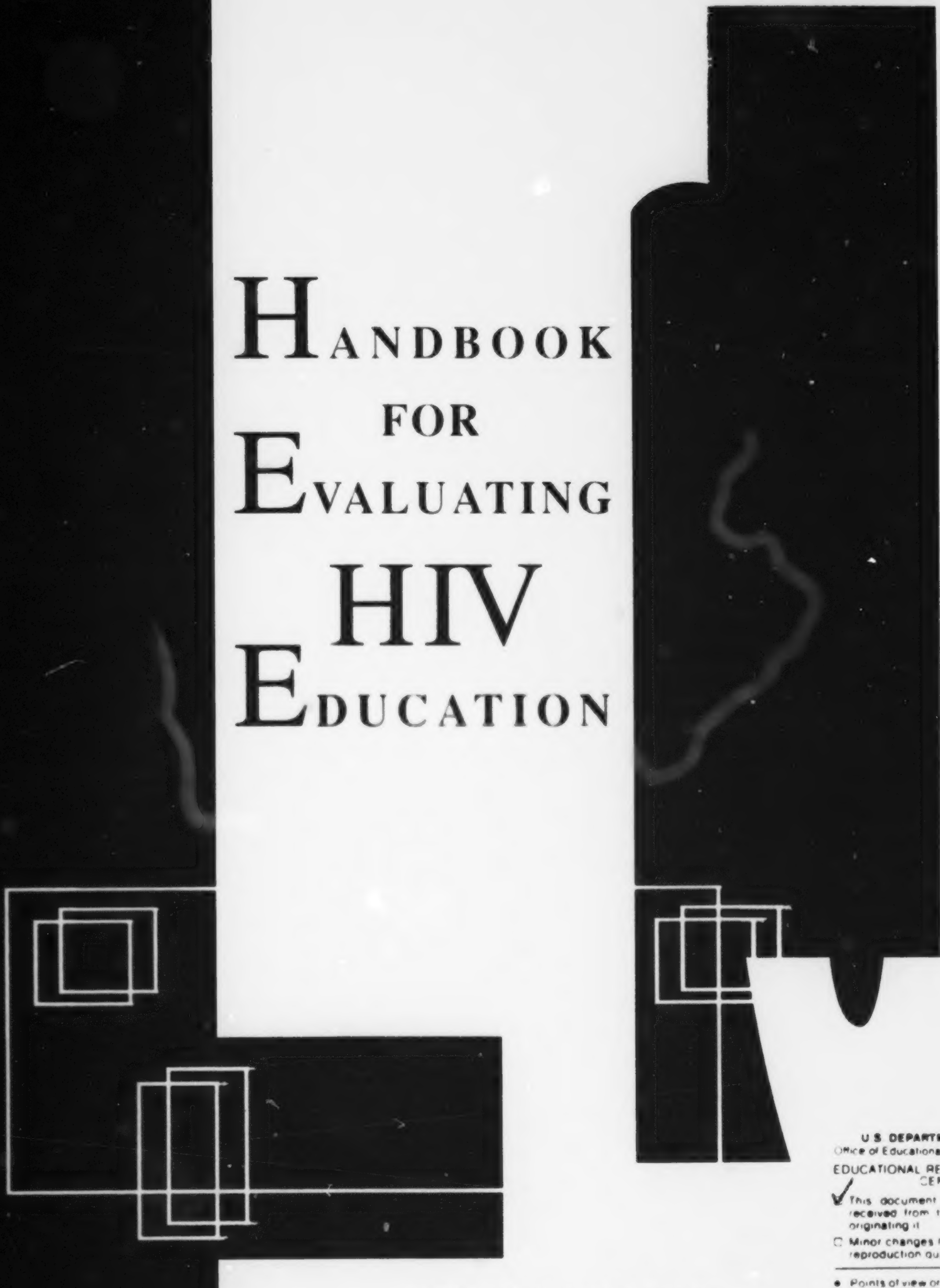

HANDBOOK FOR EVALUATING HIV EDUCATION

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ADOLESCENT AND
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NATIONAL CENTER
FOR CHRONIC
DISEASE
PREVENTION AND
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HANDBOOK FOR EVALUATING HIV EDUCATION

1. Evaluating HIV Education Programs
2. Developing and Revising HIV Policies
3. Appraising an HIV Curriculum
4. Evaluating HIV Staff Development Programs
5. Assessment Instruments for Measuring Student Outcomes: Grades 5-7
6. Assessment Instruments for Measuring Student Outcomes: Grades 7-12
7. Choosing and Using an External Evaluator
8. Reporting Results of HIV Education Evaluations

This booklet was prepared by IOX Assessment Associates under Contract No. 200-88-0683 with the Division of Adolescent and School Health, Centers for Disease Control.

Introduction

School districts across the nation have responded to the threat of AIDS by preparing students with the knowledge, attitudes, and skills they need to avoid infection with human immunodeficiency virus (HIV). In many locales, HIV-related education and infection control policies have been established, curriculum guidelines developed, and educators trained in the delivery of effective HIV prevention education. Based on a recent study of school districts nationwide, 67% required HIV education for students, 90% provided teacher preparation in the area of HIV education, and 71% reported that a school/community advisory committee had been established for the review of HIV education materials. This level of commitment to the provision of HIV education is a necessary and impressive response to the AIDS epidemic.

Local HIV prevention efforts are further supported by *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. These national health objectives for the year 2000 call for reducing the proportion of adolescents who have engaged in sexual intercourse by age 15 and by age 17 (objectives 5.4, 18.3, 19.9), reducing the proportion of ever sexually active adolescents who abstain from sexual activity for the previous 3 months (objective 5.5), and increasing the proportion of sexually active adolescents who used a condom at last sexual intercourse (objectives 18.4, 19.10). The Centers for Disease Control and Prevention (CDC) is working with national, state, and local health and education agencies to help attain these objectives, as well as to decrease the proportion of 9th-12th grade students who use injected drugs.

Although considerable effort is being expended on school-based HIV prevention education, little data are available yet to suggest whether these programs are having their intended effect. Are these programs successful in reducing HIV-risk behaviors among students? Can these programs be improved to become even more effective? To answer these questions, objective evaluations of the impact of HIV prevention programs must be undertaken.

To support the efforts of educators to evaluate the quality of their HIV prevention programs, the CDC and its contractor, IOX Assessment Associates, developed this handbook. CDC strongly encourages its cooperative agreement recipients to use these materials in the design of HIV program evaluations. Cooperative agreement recipients are also encouraged to share these materials and encourage their use with local departments of education and schools throughout their jurisdiction.

This handbook includes evaluation designs and measurement tools necessary to collect data on the basic program components of policy development, curriculum design, teacher training, and student outcomes. Although the handbook cannot serve all evaluation purposes, it reflects the need to evaluate the basic, most central aspects of HIV prevention programs.

The booklets

The *Handbook for Evaluating HIV Education* comprises eight interrelated yet separate booklets, each addressing a particular evaluation need. A brief description of each booklet is provided below:

1. *Evaluating HIV Education Programs.* Five key guidelines are described to provide a step-by-step model for the evaluation of an HIV education program.

2. *Developing and Revising HIV Policies.* The need for HIV-related policy development and evaluation is stressed. Six documents and two databases are described to aid in the development or revision of HIV-related policies. These sources provide useful recommendations to policymakers regarding the procedures used to develop HIV policies and their content. Checklists for the policymaking process and policy content are provided in this booklet to assist policymakers in judging their policies against the recommendations suggested in the cited documents. A sample educator survey is also included to help policymakers gain information from users of their policies.

3. *Appraising an HIV Curriculum.* Four guidelines for the appraisal of an HIV curriculum are presented along with a set of internal characteristics that can be used to judge an HIV curriculum's probable effectiveness.

4. *Evaluating HIV Staff Development Programs.* Four guidelines for planning the evaluation of HIV staff development programs are described. A set of assessment instruments is provided for use in such evaluations.

5. *Assessment Instruments for Measuring Student Outcomes: Grades 5-7.* Four assessment instruments suitable for the evaluation of HIV education programs for students in grades 5-7 are presented. The instruments focus on HIV-related knowledge and attitudes and on confidence in one's ability to resist peer pressure. Descriptions of each instrument and directions for administration and scoring are provided.

6. *Assessment Instruments for Measuring Student Outcomes: Grades 7-12.* Seven assessment instruments are provided for use in the evaluation of HIV education programs for students in grades 7-12. These instruments address HIV-related knowledge, attitudes, and behaviors. Descriptions of each instrument and directions for administration and scoring are provided.

7. *Choosing and Using an External Evaluator.* Seven guidelines are provided for selecting and working with an external evaluator in conducting an evaluation of an HIV education program. A form for rating prospective evaluators, a sample position description, and a sample contract are included.

8. *Reporting Results of HIV Education Evaluations.* Five guidelines are presented to assist in reporting the results of evaluation studies related to HIV education. Three sample evaluation reports are provided to illustrate use of the guidelines.

It is imperative that those involved in the design and delivery of HIV education programs assume the professional responsibility to evaluate and document the extent to which HIV programs have actually worked. We hope that this handbook will contribute to your efforts to conduct such evaluations. For further information on the use of these booklets, please contact your state HIV coordinator or your CDC project officer.

Division of Adolescent and School Health
National Center for Chronic Disease
Prevention and Health Promotion
Centers for Disease Control and Prevention

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Evaluating HIV Education Programs

BOOKLET 1

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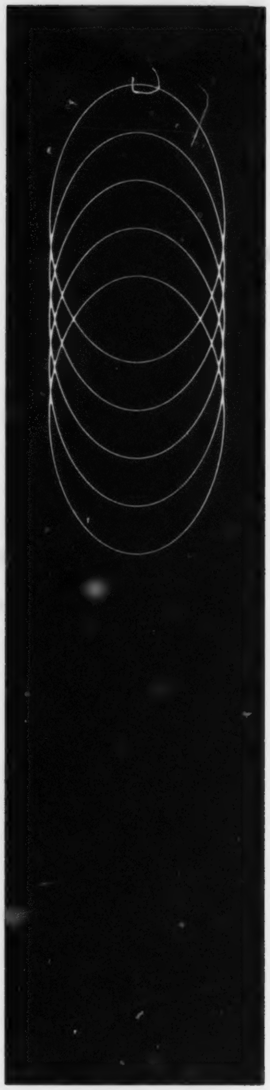

EVALUATING HIV EDUCATION PROGRAMS

W. James Popham

This booklet was prepared by IOX Assessment Associates under Contract No. 200-88-0683 with the Division of Adolescent and School Health, Centers for Disease Control.

TABLE OF CONTENTS

Page

INTRODUCTION 1
  What is HIV education? 1
  Why evaluate HIV education? 1

GUIDELINES FOR HIV EDUCATION EVALUATORS 2

  Guideline 1: Focus on a manageable number of important program-related decisions. 3
    Two kinds of decisions 3
    The role of program objectives 5
    Focusing on major decisions 6
    Must all decisions be linked to attaining objectives? 7
    Final thoughts about Guideline 1 7

  Guideline 2: Select and administer suitable assessment instruments. 8
    An emphasis on student outcome data 8
    How to acquire suitable assessment devices 10
    Securing permission to gather data 11
    Confidentiality considerations 12
    What about qualitative data? 13
    Final thoughts about Guideline 2 13

  Guideline 3: Use a data-gathering design consistent with the orientation of the evaluation. 14
    A data-gathering design for program-improvement evaluations 14
    A data-gathering design for program-continuation evaluations 17
    Sampling 19
    Final thoughts about Guideline 3 20

  Guideline 4: Use data-analysis procedures that yield understandable results. 20
    Practical versus statistical significance 20
    Comprehensibility of results 21
    Final thoughts about Guideline 4 22

  Guideline 5: Report your results using a multilevel reporting scheme featuring written and oral reports. 22
    An appropriate level of detail 23
    Oral reporting 23
    Making recommendations 24
    Final thoughts about Guideline 5 24

CONCLUSION 25

ADDITIONAL READING 27

Introduction

What is HIV education?

AIDS (acquired immunodeficiency syndrome) was identified as a new clinical condition in 1981, with HIV (human immunodeficiency virus) discovered as its cause soon after. Since that time, policymakers have responded in various ways to the crisis. Many educational policymakers have agreed that schools should provide HIV-related programs to educate students and help them eliminate, or at least greatly reduce, their likelihood of becoming infected with HIV. Such HIV education programs began to be widely offered to students in our nation's schools during the late 1980s. The fact that HIV infection almost certainly results in serious illness and premature death, makes the stakes of HIV education higher than those educators commonly face and the thorough evaluation of these programs vital. This set of basic guidelines has been designed to assist in such evaluation.

Many HIV education programs are now available for students at various grade levels, most often in junior high schools. Sometimes this HIV education is part of comprehensive school health education. In other instances, special HIV education programs are inserted into existing courses, such as psychology, science, or guidance classes. In still other situations, a separate HIV education program is offered via special assemblies or minicourses.

Placement within the school curriculum is not the only difference among HIV education programs; the duration and intensity of these programs vary as well. In some settings, there is a strong commitment to prepare students to avoid behaviors that place them at risk of HIV infection. Such HIV education programs, often provided in the context of comprehensive school health education, may extend over several weeks and strive to provide students with a wide range of skills and knowledge with which to avoid HIV infection. Other HIV education programs are, unfortunately, much less substantial. These perfunctory programs, lasting no more than an hour or two, offer students little more than the most rudimentary information about HIV and preventing its transmission.

Why evaluate HIV education?

The common aim of all HIV education programs, regardless of form or fervor, is to help students avoid becoming infected with

HIV. Not every HIV education program, of course, can successfully protect all students from HIV infection. It is precisely because of the high stakes already noted, however, that thorough judgments of a program's success are particularly important. By systematically evaluating HIV education programs, we can see whether those programs have been effective.

The five guidelines provided in the following pages are intended to assist those responsible for evaluating school-based educational programs. More specifically, these guidelines address program evaluation procedures to help (1) improve HIV education and (2) determine the success of an HIV education program. For either of these purposes, program personnel will make a number of decisions concerning the HIV education program based upon the information supplied by the program evaluation.

The guidelines in this booklet are deliberately fundamental. They are intended to assist busy educators who need to evaluate their HIV education programs efficiently. These guidelines do not deal with advanced aspects of program evaluation; numerous available textbooks provide sophisticated treatments of such topics. A set of references is included at the end of this booklet for those interested in further pursuing the topic of program evaluation.

This booklet presumes that you, the reader, need to conduct or oversee the evaluation of an HIV education program. These guidelines address key procedural steps that you can follow in carrying out an appropriate evaluation. They deal specifically with fundamentals—the nuts and bolts of evaluating HIV education. Only rarely will you find discussions of possible procedural alternatives. To keep this booklet brief enough to be read and used by busy people, the guidelines more often than not embody "do this, then that" procedural suggestions.

Guidelines for HIV Education Evaluators

The topics to be addressed by the guidelines are (1) the evaluation study's focus, (2) selecting appropriate assessment devices, (3) choosing a data-gathering design, (4) analyzing the data, and (5) writing evaluation reports. Each guideline will be addressed by discussing the reasoning behind it and describing how it should be implemented. Although the guidelines are provided in a rough sequential order, you may find that you need to skip a step or repeat some steps more than once along the way.

Guideline 1: Focus on a manageable number of important program-related decisions.

When many educators hear the expression "educational evaluation study," they almost instinctively think of a study designed to determine if an educational program is *good* or *bad*. That view of educational evaluation, fortunately, is way off the mark. An educational program is evaluated for one fundamental reason: to provide information to help people make better decisions about the program.

Focus on a reasonable number of decisions.

Properly conceived educational evaluations help decision makers arrive at better decisions. The evaluator's responsibility, then, is to gather information, or evidence, for these decision makers. Sometimes, of course, the evaluator of an HIV education program will be the same person who manages the program.

The kinds of decisions that must be made by those who staff an HIV education program might deal with (1) what content to include in the program, (2) how much instructional time to allot to different topics, (3) how to organize instructional components effectively, and (4) what to do when certain parts of the program appear to be unsuccessful.

Two kinds of decisions

Decisions that relate to educational programs can be classified into two major categories. The first category includes decisions that improve the program and allow it to function more effectively. These are *program-improvement* decisions. The second category focuses on more fundamental go/no-go decisions, that is, whether to continue or discontinue the program. These decisions are *program-continuation* decisions. A decision might be made, for example, to terminate an existing HIV education program and replace it with a substantially different program. The type of decisions that need to be made directly determine the type of information you seek and the approach you will take in your evaluation.

If you are carrying out an evaluation study designed to assist with program-improvement decisions, you can be decidedly partisan. You are in every sense a "member of the team," and your chief responsibility is to boost program effectiveness. As we will see, a program-improvement evaluator can use data-gathering techniques that would be a poor choice for program-continuation evaluations.

On the other hand, when carrying out a program-continuation evaluation study, you must be completely objective and non-partisan. Your evaluation should be governed by your need to supply accurate and credible evidence to those who will decide whether to continue the program.

Decision makers associated with an HIV education program typically fulfill one of two functions. First, they may be people who actually design and/or deliver the HIV education itself. These typically are teachers or health education curriculum specialists. Such people are mainly concerned with decisions to improve the program. Program-improvement evaluation studies are particularly appropriate in the early years of a program's existence when the instructional staff is trying to eliminate the program's deficits and make it stronger.

The second category of decision makers consists of those who authorize or fund an HIV education program. School board members at the district or state level usually set the policies that establish the programs. State or federal officials often supply funding for the programs. Both program authorizers and program funders are usually more concerned with program-continuation decisions than with program-improvement decisions. Program-continuation evaluations usually are made after a program has been in place for a few years, when it is appropriate to determine if the program is worth the money it's costing.

Most decision makers with whom you will work think of educational evaluation exclusively as a program-continuation enterprise. When many school board members or district-level administrators hear the phrase "evaluation study," they immediately imagine a study designed to determine whether or not they should continue the educational program. One of your tasks as an evaluator is to *educate* decision makers to realize that it often makes sense to evaluate programs in order to improve them, particularly in their early years of existence.

Some people mistakenly assume that once a program has been evaluated, there is no need for further evaluation. In fact, however, program evaluation should be conceived of as an ongoing enterprise. As early versions of the program are offered, they can be improved via program-improvement evaluation. Later, when the program staff believe the program is sufficiently mature, a program-continuation evaluation might be undertaken. But even mature programs can be improved. Thus, evaluation of programs for program improvement should be a continuing activity.

It is sometimes thought that evaluations of HIV education are successful only if they reveal that the program was effective. On the contrary, an evaluation that reveals a program's shortcomings can point the way to program improvements and ultimately program effectiveness. Evaluations that enhance the quality of decisions are successful evaluations.

Guideline 1, to focus on a manageable number of important program-related decisions, stems from a basic human shortcoming: people can only make use of so much data. If they are given too much information, even at their own request, they are likely to become overwhelmed and, as a consequence, pay attention to none of it. The decision makers for whom you gather evidence in your evaluation will be no different. They will often want more answers than they can really use.

Regardless of whether you pursue an evaluation study aimed at program improvement or program continuation, one of your early tasks is to focus on an intellectually manageable number of decisions related to the HIV education program. Skillful evaluators focus on significant decisions, not "nice to know" information.

The role of program objectives

An HIV education program staff usually aspires to bring about worthwhile changes in students. Those changes can focus on altering either students' HIV-risk behaviors or the factors thought to contribute to such behaviors. Put most simply, an instructional objective for an HIV education program should describe the post-program knowledge, skills, attitudes, or behaviors that the program seeks to promote. This is nothing more than a classic ends/means distinction. Identifying a program's objectives can lead to identifying the decisions on which you will focus your evaluation.

A number of educators attempt to describe educational objectives as what the program itself will do rather than what it is intended to accomplish. Educational objectives have nothing to do with what the HIV education program is or how it was created. Instead, the objectives for HIV education must focus on program outcomes—that is, on what happens to students as a consequence of the program. Clearly stated, measurable objectives will provide a valuable yardstick for your evaluation of a program's effectiveness.

If you can help a program's staff identify the objectives that they hope to accomplish, and if you can help the staff define those objectives as preprogram-to-postprogram changes in students, you will have gone a long way toward clarifying the focus of your evaluation. You can then recognize and isolate evidence bearing on key program decisions.

Evaluators who wish to use an HIV education program's objectives to their advantage will need to be sure that the program is organized around only a handful of measurable objectives. Some researchers cite evidence suggesting that people have a difficult time concentrating on many more than six or seven issues at a time. Rarely permit your evaluation, therefore, to be organized around more than a half-dozen or so objectives—preferably fewer.

A program staff may have a number of fine-grained instructional objectives to use in day-to-day instruction. As an evaluator, however, your responsibility is to isolate a few educational objectives that subsume such day-to-day objectives, then gear your data-gathering toward that smaller number of important objectives.

Focusing on major decisions

One of the best ways for you to focus an evaluation study on a manageable number of decisions is to encourage decision makers to identify their most important program-related decisions. Work with decision makers to identify the one most important decision at issue, then the next most important decision to be informed by the evaluation study, and so on.

Another useful ploy to reduce the number of decisions is to group small-scope objectives into one broader yet still measurable objective. Suppose you were carrying out a program-continuation evaluation of HIV education for a district's school board. You have learned that the teachers providing the district's HIV education program have listed four different objectives each dealing with a distinctive type of knowledge students need to acquire, such as "knowledge regarding HIV infection routes" or "knowledge regarding HIV-risk behavior patterns of teenagers." It would be relatively simple to create a single objective, "increased HIV-relevant knowledge," to effectively coalesce the four small-scope objectives. The teachers can still organize day-to-day instructional activities around small-scope objectives, and you can focus your evaluation on broad-scope objectives.

In spite of your efforts to focus on a limited number of decisions, some decision makers may request information simply because it would be "interesting." Keep urging these persons to indicate how their requested information would actually make a difference in a decision dealing with the HIV education program.

One good way to verify whether a requested set of evidence really bears on a program-related decision is to present decision makers with hypothetical results and ask, "If the evidence turns out this way, what would your decision be?" Then present a divergent set of information, asking, "If the evidence turns out the opposite way, what would your decision be?" You may discover that it makes no difference to decision makers what the results are. In such instances, of course, encourage these persons to seek other, more relevant evidence.

Must all decisions be linked to attaining objectives?

Although the decisions addressed by evaluators are often linked to the achievement of a program's objectives, decision makers face many choices that do not depend on the attainment of objectives. For example, evaluators often gather evidence as to whether an instructional program is being delivered as intended. The decision at issue in this instance would be whether the program's staff must take steps to ensure that the program is being provided as its designers intended.

Other such decisions include (1) whether community officials will permit controversial topics to be addressed in instructional activities, (2) whether students will regard HIV-related information as more believable if provided by peer counselors rather than teachers, and (3) whether the program's objectives are appropriate. There are also instances in which unanticipated effects of the program, that is, effects not foreseen in the program's objectives, might be significant in judging a program's effectiveness.

In short, although the degree to which an HIV education program's objectives have been achieved can illuminate certain kinds of decisions, other kinds of decisions will demand that the evaluator adopt alternative approaches.

Final thoughts about Guideline 1

The purpose of evaluating HIV education programs is to help those who must make decisions about the program do so in an appropriate manner. You will discover that evidence gathered in an evaluation study often plays only a minor role in the decisions ultimately made about a program. For many decision makers, a series of political and personal factors play a far more prominent role than any evidence of program effectiveness provided by an evaluator. As an evaluator, therefore, you will need to structure your evidence-gathering efforts to yield information that has at least a reasonable chance of affecting the decisions to be made.

Guideline 2: Select and administer suitable assessment instruments.

One of the evaluator's most important tasks is choosing which information to assemble for decision makers. Guideline 2 deals with the instruments you will use to gather decision-relevant data.

Secure and use assessment devices.

Evidence regarding changes in student behavior, which is the outcome typically sought by educational programs, can be described as *outcome data.* Outcome data represent the effects of an educational program. Evidence regarding the nature of the educational process itself, in contrast, is referred to as *process data.* Typically, process data are gathered when the evaluator wants to determine whether an instructional program is being provided as intended.

A variety of "process instruments" are provided in this handbook regarding the quality and implementation of HIV-related policy, curriculum, and staff development programs. In addition, CDC recommends using the *HIV Education Survey*, developed cooperatively with state and local education agencies, to collect data on HIV education programs. The *HIV Education Survey* collects information on the number and percentage of schools providing and the number and percentage of students receiving HIV education, as well as on teacher training, curriculum, content, scheduling, provision within special education, and barriers to instruction. A handbook for conducting this survey and software to assist with selecting schools and summarizing data are available from CDC (404/488-5330) or Westat, Inc. (800/937-8287).

An emphasis on student outcome data

Students receiving the HIV education program supply the bulk of the data the evaluator typically gathers. One method of gathering such data might be to have students participating in the program fill out anonymous questionnaires. Because evaluators in most cases will be interested in the changes in student behavior resulting from HIV education, a questionnaire will typically be given to students both before and after the program.

Evaluators of HIV education programs should attempt to secure four types of student outcome data:

- Evidence of the extent to which students engage in HIV-risk *behaviors*

- Evidence of students' ability to display key *skills* needed to reduce their likelihood of being infected with HIV
- Evidence of students' *attitudes* that are likely to influence their HIV-related behaviors
- Evidence of students' *knowledge* regarding those aspects of HIV and AIDS apt to influence their HIV-related behaviors.

As we see, the four categories of student outcome measures are behavior, skills, attitudes, and knowledge.

The same four general categories of outcome data can be used to evaluate HIV staff development programs for teachers who will deliver the instructional program for students. In these staff development activities, of course, teachers are the "students." Although the nature of these outcomes will be different, the categories remain essentially the same. Table 1 presents illustrations of the sorts of outcome evidence that might be sought when evaluating (a) an HIV education program for students and (b) a staff development program for teachers who will provide HIV education. (Although the guidelines provided in this booklet are directed toward the evaluation of student-focused HIV education, in most instances they can also be used to evaluate staff development programs for HIV educators.)

Table 1. Illustrations of Relevant Types of Evidence for Students and Teachers in HIV Education Programs

Evidence Category	**For Students' HIV Education**	**For Teachers' HIV Staff Development**
Behavior	Reported activities while in high-risk situations	Appropriate use of recommended classroom procedures
Skills	Ability to display refusal skills in simulated high-risk situations related to HIV infection	Ability to respond appropriately to students' questions about sensitive topics
Attitudes	Perceptions regarding one's personal susceptibility to HIV infection	Confidence in being able to modify students' high-risk behaviors
Knowledge	Knowledge regarding the routes by which HIV is/is not transmitted	Knowledge regarding the instructional principles relevant to modifying students' attitudes

Even though the program's decision makers will ultimately decide the sorts of evaluative evidence you should collect, you should certainly encourage them to gather behavioral data in nearly all evaluations of HIV education. Many HIV education programs only attempt to influence students' knowledge regarding HIV. Yet ample evidence indicates that knowledge-only programs typically have scant influence on students' behaviors.

Ideally, you should encourage the use of an assessment strategy in which evidence is gathered about students' behavior, skills, affect, and knowledge. The nature of the HIV education program itself will prominently determine which outcomes you should measure.

Of the four types of outcome data from students, the most important is behavioral data. Strive to collect student behavioral data if at all possible. This will sometimes oblige you to provide education and information to local community groups to overcome obstacles on the collection of sensitive behavioral data. Try as hard as possible to assemble evidence of the HIV education program's impact on students' HIV-risk behaviors. Without such evidence, a misleading picture of the program's effectiveness can emerge. HIV education programs that enhance only students' knowledge or attitudes may be judged effective when behavioral data would indicate otherwise.

It is difficult, of course, to demonstrate that an HIV education program has produced genuine changes in young people's behaviors. Part of the difficulty lies in having a sufficient period of time to discern changes in behavior. Program effectiveness may not be apparent for six or more months following the intervention, particularly if rates of sexual intercourse are low. Nevertheless, the program's staff has a responsibility to judge its efforts according to the changes that take place in students' behaviors.

How to acquire suitable assessment devices

Once you have decided to measure the four types of student outcomes we have been discussing, where do you get your assessment instruments? There are two possible ways to proceed. You can either construct the instruments yourself or use (perhaps adapt) existing instruments. In selecting, adapting, or constructing your assessment devices, it is extremely important to ensure that they match your program objectives. Measuring an attitude or behavior change that was not sought as part of your instructional program may set up the program for failure.

The problem with creating your own assessment devices is that wording questions to assess behavior, skills, and attitudes is exceedingly tricky. Most educators have substantial experience in developing knowledge tests, but those sorts of assessment instruments are far easier to create than the other three types. Unless you have training and experience in the development of assessment instruments, it makes much more sense to use existing ones.

A set of assessment instruments designed to evaluate HIV education programs for students in grades 5-7 and 7-12 is provided in other booklets contained in this handbook. Start first by carefully considering whether some of these assessment devices will meet your needs; if not, you may need to create or adapt your own instruments. Because the development of acceptable assessment instruments for HIV education evaluation is extremely difficult, however, try to enlist the assistance of experienced test-developers to ensure the quality of your instruments.

Securing permission to gather data

Asking students questions about their sexual activities is considerably different from asking them about the Civil War. Because sexual activity is the most common way HIV is transmitted, your assessment instruments will often contain questions about students' sexual behaviors. It is essential that you clear your intended assessment instruments with appropriate school-district authorities. A special review group consisting of educators, parents, and other citizens will often have been established to judge the acceptability of HIV education materials and data-gathering instruments. The assessment instruments included in this handbook should be cleared by a local review group.

You should follow established district procedures in the use of assessment instruments dealing with sensitive subjects such as sexual conduct or drug use. Some districts require that either *active informed consent* or *passive informed consent* be secured from parents of students prior to the administration of such assessment devices. With active informed consent, a letter is sent to a student's parents or guardians describing the general nature of the intended data-gathering and asking permission for the student to complete the assessment instruments described. This letter must be signed by parents or guardians indicating their permission to have the data-gathering instruments administered to the student. With passive informed consent, a similar descriptive letter is sent to the student's parents or guardians. They are required to sign and return it, however, only if they do *not* wish the student to complete the assessment instruments. Obviously, because active informed consent requires the receipt of a signed authorization letter from parents, it is the more difficult to implement. Most school districts already have policies in place regarding whether active or passive informed consent is required for data gathering.

The sorts of assessment instruments that might offend local citizens varies greatly among communities. This is an opportunity for you to play a significant educational role with local officials. If fears of citizen disapproval lead to the elimination of questions dealing with key HIV-risk behaviors (such as sexual behavior), you will be unable to discern whether the HIV education program is accomplishing some of the outcomes that it ought to accomplish. You may need to apprise local officials of the deadly threat to students engaging in HIV-risk behaviors and of the consequent peril to those students if educational programs to reduce HIV-risk behaviors are ineffective. When local officials, parents, and guardians are made aware of this serious potential, they will usually allow reasonable questioning about high-risk behaviors.

Confidentiality considerations

Once you have secured approval to administer suitable assessment instruments as part of your HIV education evaluation, you must structure the data gathering to increase the likelihood of getting truthful responses from students. To promote this, you should employ as many procedures as possible to enhance anonymity. Any such procedures should be announced to students in advance to assure them you do not intend to associate them with their responses.

Students should complete all instruments anonymously. Moreover, to remove the possibility that an individual's handwriting can be recognized, students should not be asked to write any words on the instruments. Instead, have students use only checkmarks or similar sorts of responses to all items. Similar, nonidentifiable pencils or pens should be used by everyone. In addition, students should place their own completed instruments in large envelopes or opaque containers that help avoid identifying the respondent. If possible, arrange seating to make it difficult for students to see each other's answers. (Several of the evaluation instruments in this handbook employ a response scheme specifically designed to prevent students from "inadvertently" seeing how others respond to items dealing with sensitive subjects such as sexual behavior or the use of illegal drugs.)

In short, make sure that you have taken all reasonable steps to assure students of confidentiality and anonymity. Even then, of course, not all students will respond honestly to all questions. If, however, your efforts to ensure confidentiality boost the number of candid responses, your interpretations of the resulting data will obviously be more accurate. Fortunately, your quest is to evaluate program effectiveness rather than the status of individual students.

What about qualitative data?

So far we have dealt with the sorts of data gathered via fairly traditional quantitatively based assessment instruments. There are also a number of more qualitatively oriented data-gathering procedures, such as focus group interviews or one-on-one interviews with students who have received an HIV education program. These types of procedures often provide a rich source of explanatory evidence to help decision makers better understand the nature of the evidence you supply to them. For example, a few focus group sessions with students who have completed an HIV education program can prove particularly illuminating if the evaluator is trying to figure out which parts of the program worked well and which parts did not.

Final thoughts about Guideline 2

It is difficult to say that one guideline is more important than another, for all guidelines should play pivotal roles in your evaluation of an HIV education program. Guideline 2, however, leads directly to the assembly of the chief evidence you will use. To fail to identify appropriate assessment instrumentation, therefore, is to lose the whole evaluative ball game.

Few test developers are skilled enough to craft instruments that tease out subtle nuances in students' attitudes or garner honest answers to sensitive questions about sexual activities. The assessment instruments provided in this handbook were developed and field-tested by measurement experts and reviewed by specialists in the field of HIV prevention. You should review these instruments to see if they suit your needs. You should also consider the usefulness of qualitative data-gathering approaches, because schemes such as focus group interviews provide evidence that blends well with more quantitatively oriented evidence.

In addition to selecting appropriate assessment instruments, attention must be paid to obtaining needed permissions and enhancing student anonymity. Be sure that you attend to all three of the elements in this critically important guideline.

Guideline 3: Use a data-gathering design consistent with the orientation of the evaluation.

Once you have identified the assessment instruments you will use in your evaluation study, you must next determine your data-gathering design. Putting it more simply, you must decide how and when to administer the assessment instruments.

To keep these guidelines simple, we will consider one data-gathering strategy for program-improvement evaluation studies and one for program-continuation studies. If you want to explore other options, you can find a wide array of choices in almost any textbook on research methods for the behavioral sciences.

A data-gathering design for program-improvement evaluations

Choose a data-gathering design.

Let's assume you are carrying out a program-improvement evaluation of a district-level HIV education program. The chief decision makers involved are the teachers and curriculum specialists who planned and implemented the program. You must secure evidence to help these decision makers make their program more effective. As an evaluator, you are not trying to *prove* that the HIV education program works. Rather, you intend to provide your colleagues with data-based insights to help them *improve* their program. Your choice of a data-gathering design, then, should be consistent with that orientation.

The recommended data-gathering design for program-improvement evaluations of HIV education programs, presented in Figure 1, is known as the *one-group pretest-posttest design*. As seen

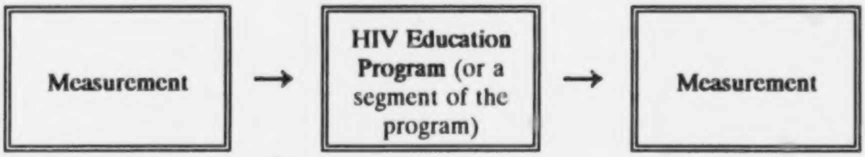

Figure 1. *A one-group pretest-posttest design*

in Figure 1, this design involves a preprogram measurement and a postprogram measurement. If one of your instruments is an anonymous questionnaire regarding students' HIV-risk behaviors, for example, you would administer that questionnaire to students before and after the program. Differences between the pretest and the posttest data would be credited to the program's effects.

The HIV education program, of course, is not the only possible reason for a change between students' pretest and posttest questionnaire responses. As students grow older, increased maturity may alter their approach to HIV-risk situations. Similarly, if they discovered that one of their classmates is infected with HIV, it will have a tremendous impact on their responses. These events, unrelated to the program, can pose interpretive problems for program-continuation evaluators, who must often prove a program's effectiveness to incredulous decision makers and must, therefore, use data-gathering designs that control for such factors. The program-improvement evaluator, however, usually has no such constraints and often needs only to point out that extraneous factors may have influenced the results.

You will note in Figure 1 that the pretest and posttest measurements may be used not only with the HIV education program in its entirety, but also with segments of the program. Suppose an HIV education program devoted three class periods to promoting students' refusal skills in situations that might involve high-risk sexual activity. If the program's staff were eager to improve this segment of the program, you could gather presegment and postsegment evidence from students to see if the three-day treatment of refusal skills led to increases in students' measured ability to apply those skills. If the presegment-to-postsegment gains were as the staff hoped, the program would not need modifying. On the other hand, if the presegment-to-postsegment gains were too small or nonexistent, alterations would be in order.

Here is a more detailed illustration. You are assigned to evaluate a school district's HIV education program for improvement purposes. Although the program has been in place for several years, the district's school board has asked administrators to ensure that the program is as effective as possible. Your job is to help teachers identify the parts of the program in need of revision.

You meet with the district's HIV education teachers and agree on five assessment instruments consistent with the program's stated objectives. The five instruments are: (1) an HIV knowledge test, (2) a test of students' refusal skills, (3) an attitudinal inventory assessing students' perceptions of their vulnerability to HIV infection, (4) an attitudinal inventory reflecting students' belief that they can take actions to reduce their likelihood of HIV infection, and (5) a questionnaire regarding the extent to which students engage in HIV-risk behaviors.

The district's HIV education program consists of fifteen hours of HIV-specific instruction during a required tenth grade health education class. You administer the five assessment instruments before and after the classes and discover that students display substantial progress on the knowledge and skill instruments but almost no change on the behavioral questionnaire, your most important instrument, or on the two attitudinal inventories. Such results would place you in a position to suggest that program alterations are warranted. Because the promotion of students' skill and knowledge appears to be successful, you might suggest that parts of the program be modified to better address the two attitudinal dimensions (students' perceived vulnerability and self-efficacy), and their behavior. If you are familiar with instructional psychology, you might suggest particular modifications in the instructional procedures used by the teachers. If you do not possess such knowledge, you could suggest that the HIV education staff rethink the dimensions on which little student progress is evident. You might also, at this point, seek qualitative data from student interviews—individual or focus group sessions—about which program components the students thought did or did not work.

One disadvantage of this design, as we have discussed, is the possibility that factors other than the HIV education program have influenced students' pretest-versus-posttest responses. You will have to be attentive to such possibilities. If other events, such as the release of a popular film about AIDS, occur during the period that the HIV education program took place, you will need to describe them in your report.

Another potential disadvantage of this data-gathering design stems from the use of the same assessment instruments before and after the program. The use of a pretest may result in a *reactive* effect by alerting students to what they are expected to get out of the program. Students may react differently to the program than they would have merely because the pretest let them know "what's important" in the program. If you are considering assessment instruments you fear would be reactive, you may wish to consider alternative data-gathering approaches such as those described in the additional readings at the end of this booklet.

A data-gathering design for program-continuation evaluations

The initial consideration in selecting a data-gathering design for program-continuation evaluations of HIV education is the confidence with which you can supply convincing evidence about the program's effectiveness. Although a data-gathering scheme such as the one-group pretest-posttest design might prove satisfactory for program-improvement purposes, it does not fill the needs of program-continuation evaluators wishing to supply evidence about whether a program really worked. You need a data-gathering design that allows you to make defensible statements about an HIV education program's success—or lack of it. And because the evaluation of school-based HIV education programs must take place in the midst of ongoing education programs, a data-gathering design must be selected that can be realistically implemented in a school setting.

The *pretest-posttest two-group design*, portrayed in Figure 2, provides the strongest basis for a program-continuation data-collection scheme to address these considerations. This design involves two groups, with only Group 1 initially receiving HIV education. Group 2 begins as an untreated control group.* This data-gathering design requires that a preprogram measurement be given to both groups. After Group 1 has completed the HIV edu-

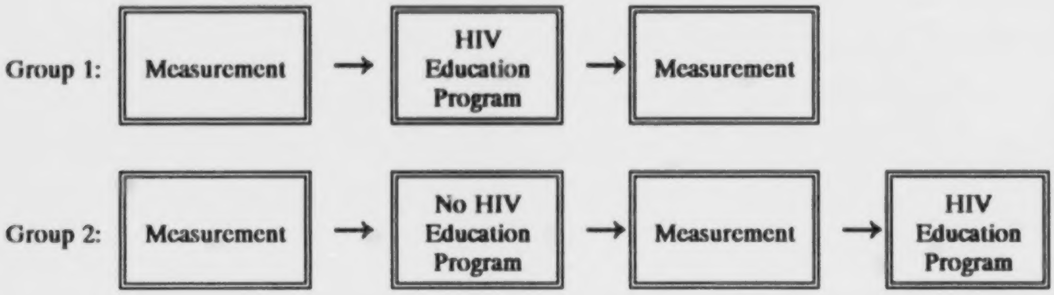

Figure 2. *A pretest-posttest two-group design*

cation program, both groups are posttested. Because an effective HIV education program will provide students with content that can quite literally save their lives, the prospect of employing a data-gathering design in which an "untreated control group" of students receives no HIV education runs counter to our sense of educational responsibility. Therefore, enough time must be set aside during the school year to insure that Group 2 also receives the HIV education program after the posttest.

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*If Group 2 is not receiving any HIV instruction, it is termed the "control group." Sometimes, however, Group 2 is receiving a different intervention (perhaps an earlier version). Group 2 is then called the "comparison group."

The key comparisons in this two-group design are those between the pretest-to-posttest changes made in Group 1 (the treated group) and those made in Group 2 (the untreated group). If Group 1 outperforms Group 2 on the posttest, it would indicate that the program is effective. If there is no difference between the two groups' pretest-to-posttest changes, or if Group 2 outperforms Group 1, a lack of program effectiveness is indicated.

Interpretations of the effectiveness of the HIV education program, however, are totally dependent on the degree to which students in the two groups are similar. If the groups are essentially the same, you can draw meaningful conclusions as to whether the HIV education program worked. As the two groups become less similar, the conclusions to be drawn become less meaningful. For example, one of the concerns with classroom-based evaluations is that students in one classroom are different from students in another classroom. One reason for this is that students may be assigned to particular classes on the basis of their ability or interests. When classroom assignments are not made randomly, it is impossible to assume that students within those classrooms will be similar. Therefore, if the two groups (treated and untreated) are composed of only two different classrooms, it is nearly impossible to determine whether posttest differences are due to the intervention program or to differences among students in the individual classrooms.

One solution to this problem is to increase the number of classrooms to at least two per intervention and two per control group. The more classrooms that can be included per group, and the more randomly those classrooms can be selected from all possible classrooms, the more likely it is that the students in the intervention and control groups will be equivilant at the pretest. If a large number of classrooms (e.g., 20) can be randomly selected from the school district and randomly assigned to treatment or control situations, then a "posttest only" design may be used, in which only differences between posttest scores are examined (because we feel confident that students' scores were equivilant to begin with).

Of course, it is not always possible to study many classrooms at one time, or to select classrooms randomly from the school district. In that case, it is important to use pretest scores in the analysis to control for the potential lack of confidence about initial equality. This more common situation is analyzed in a "pretest-posttest (nonequivilant) two-group design," which is shown in Figure 2.

It may also be important to consider that the intervention could have different effects on different types of students. Age, gender, or ethnicity, for example, may be key indicators of a student's receptivity to some or all intervention components. Therefore, it may be important to analyze the results on the basis of key student characteristics. This is a somewhat more complicated design. It will require a bit more work to set up, and will need more students than the simpler designs described above. Data analysis could also be more complex. However, if particular student characteristics are responsible for different reactions to the intervention program, then it would be well worth the effort to examine those differences in the analysis which will, hopefully, lead to more meaningful results. Finally, the location of the schools within a given district may also have an effect on the results for a number of reasons. Therefore, it may be desirable to try to match classrooms from schools in similar neighborhoods, and/or with similar student populations and then randomly assign one of each pair to the treatment and the other to the control condition.

Sampling

Whenever possible, several schools should be randomly sampled from the school district for inclusion in the study. Random sampling can be as simple as pulling school names from a hat containing all school names, and then randomly selecting one or two classes from each school. These classes can be randomly assigned to treatment or control conditions by the flip of a coin.

If you are interested in matching schools on a key set of characteristics, the school district office may have relevant information on school location and student composition. You may then want to group all district schools into different types, such as urban versus suburban, and then randomly sample from within each group. Preselecting groups of schools from which to draw your random sample is known as stratified sampling. These and other sampling procedures are described in most standard research-oriented textbooks.

Final thoughts about Guideline 3

There are many more data-gathering strategies than the two basic models presented here. In the evaluation of HIV education programs, however, you will find that these two designs will satisfy almost all of your data-gathering requirements.

The one-group pretest-posttest design is recommended for program-improvement evaluations. A two-group variation of that design is recommended for program-continuation evaluations. Although it is certainly possible to use a one-group design in program-continuation evaluations, its results will not be as convincing as if a control group were used. It is equally possible to use a control-group design in program-improvement evaluations. You may find, however, that control groups often add needless complications to an evaluation focusing on program improvement.

Guideline 4: Use data-analysis procedures that yield understandable results.

Once you have gathered your data, that evidence must be summarized in such a way that is understandable to decision makers.

Practical versus statistical significance

Analyze the evaluation study's data.

Evaluators sometimes carry out data-analysis procedures that produce enough statistics to be "respectable." Such evaluators, however, must remember their audience. Unfortunately, statistical procedures that are among educational *research's* most useful tools are sometimes inappropriate for educational *evaluation*. In general, the audience for an educational researcher's efforts consists of other researchers or scholars to whom subtle, statistically significant differences may be quite important. The audience for evidence gathered by evaluators of HIV education, however, will most often be teachers, board members, or educational administrators. By and large, such decision makers are concerned with practical rather than statistical significance. A practically significant question might focus on whether a program's effect is large enough to warrant actions such as expanding the program's applications to other settings. In some cases, sophisticated statistical analyses can render an evaluation study's results virtually incomprehensible.

Comprehensibility of results

As an HIV education evaluator, you will need to analyze data in the manner most appropriate to yield easily understandable results for decision makers. This usually leads to analyses involving easy-to-read indices such as percentages and arithmetic averages or easily understood data-representation schemes such as bar graphs. In recent years, most people have become familiar with news reports of surveys having an error margin of plus or minus a certain percent. If you can analyze your data so that the results can be cast in a form accompanied by a given error percentage, most decision makers will intuitively understand what you are reporting.

If more sophisticated analysis approaches are used, make sure that results can be easily communicated to decision makers. For example, analysis of covariance is a statistical procedure often used to account for initial differences between groups of students. Were you to employ this data-analysis technique, your report to decision makers could be something along these lines: "After statistical adjustments were made for the fact that the two groups were not initially equal, the HIV education group had 13 percent fewer reported incidents of unprotected sexual intercourse."

Suppose that, prior to an HIV education program, 35 of 100 students reported that they routinely had sexual intercourse without using a condom whereas several months after the program's conclusion only 28 of 100 reported such behavior. In other words, there was 20 percent reduction in sexual intercourse without a condom among students who engaged in such a behavior. These sorts of percentage-based results are easy for decision makers to interpret. People can make sense of percentage-based differences between students' preprogram and postprogram performances because people are used to dealing with percentages in other aspects of life. Most people are not used to dealing with statistically significant differences at the .05 versus .01 probability levels.

Percentage-correct may not be a suitable descriptive scheme for all assessment instruments you choose. For example, you might use a ten-item attitudinal inventory focusing on students' perceived ability to use refusal skills that yields scores from 10 points (low perceived ability) to 50 points (high perceived ability). For such an instrument, an arithmetic average of students' scores would be more sensible than results expressed as percentages.

Because you will typically be looking at preprogram and postprogram data for your evaluations, it will be a routine matter to compare the differences between such data to discern whether the

HIV education program yielded its anticipated effects. Simple pretest-to-posttest percentage changes will usually fill the data-analysis bill satisfactorily.

Final thoughts about Guideline 4

This fourth guideline stresses the desirability of using data-analysis schemes that yield understandable results. You will discover in most instances that simple statistical procedures will take care of your data-analysis needs. In those few cases when you might need more sophisticated statistical analyses, you may wish to call on a statistical consultant to provide you with additional data-analysis guidance. Such situations might arise when it is unclear whether a difference in the performances of treated and untreated students is large enough to be meaningful.

One reason that Guideline 4 is included in this set of suggestions for HIV education evaluators is to dissuade you from believing you must carry out all sorts of complicated data analyses to make your evaluation study respectable. This is simply not the case. Your task as an evaluator of HIV education programs is to help the program's decision makers come up with better decisions. To be useful to busy decision makers, data-analysis procedures should lead to straightforward, readily interpretable information regarding program effectiveness.

Guideline 5: Report your results using a multilevel reporting scheme featuring written and oral reports.

If you design and carry out your evaluation study following the first four guidelines, you will have an intellectually manageable set of evidence—primarily student pretest and posttest data—bearing on a modest number of important program-relevant decisions. Your task at reporting time is to present that evidence to decision makers in a form most likely to influence the decisions they need to make.

Report the evaluation study's results.

An appropriate level of detail

Before reporting your evaluation study's results, you will typically find yourself in a dilemma over the suitable level of detail to include. To report concise results for busy decision makers, you would invariably need to leave out important information about such matters as the specific procedures used to assure student anonymity. On the other hand, if you chose to report the evaluation's procedures in full detail, the resulting report would often be so lengthy that decision makers would be put off by its size.

Fortunately, there is a way out of this bind: prepare two written reports. The first report should be very brief (no more than a few pages in length) and should hit only the high points—namely, the evidence that bears most directly on the decisions at issue. This brief *executive report* should direct readers who wish more information to a *technical report* that describes the evaluation study's procedures and results in greater detail. Even with the more technical report, however, you must employ good sense regarding the level of detail acceptable to the decision makers you are attempting to serve. Too often, evaluators become caught up in the intricacies of their evaluation study's procedural nuances and tend to create excessively lengthy reports. Evaluation reports perceived as hyper-detailed will rarely be read by anyone except the evaluators who prepared them. Thus, even the technical report should be sufficiently succinct and focused so that decision makers will be inclined to use it.

In any evaluation report, try to use visual and/or graphic methods to make the results as palatable to readers as possible. Few decision makers relish the prospect of reading even three pages of single-spaced prose. Although it may be difficult, particularly in the executive report, use white space and graphic presentation techniques that stimulate the reader's interest.

Oral reporting

Increasingly, educational evaluators are being asked to supplement written evaluation reports with oral presentations to, for example, a district's school board or the teachers staffing the district's HIV education program. Such sessions provide you with an excellent opportunity to educate decision makers about the impact of your study's results on the decisions they face. The give-and-take discussion that often follows an evaluator's oral report is a wonderful forum for such educative efforts.

Be sure to devote enough preparation time to make your oral reports polished, professional, and decision relevant. If you are only asked to give a written report, encourage decision makers to allow a brief oral presentation highlighting the study's key results.

Making recommendations

Another issue you are apt to face when you make your report is whether to offer recommendations to decision makers. Suppose the pretest-posttest results of a program-improvement evaluation study regarding a one-week unit dealing with refusal skills indicate that the unit was particularly ineffective. Students' skills after the unit are essentially the same as before the unit. A logical recommendation would be that the unit be seriously overhauled. But should you make such a recommendation? Similarly, if your program-continuation evaluation study indicates that an HIV education program is having a decisively beneficial impact on reducing students' HIV-risk behaviors, should you recommend that the program be continued?

Evaluation specialists are divided over this issue. For some specialists, making decision-related recommendations is a logical extension of the evaluator's decision-facilitation role. Other specialists, however, regard evaluator-generated recommendations as intrusions on the decision maker's prerogatives. These individuals believe that the evaluator should supply evidence only and should offer no guidance regarding program decisions.

It is suggested, therefore, that you be guided by decision makers' expressed preferences. You will doubtless have met with decision makers during the early stages of designing your study, for you clearly need to find out what their important decision points really are. At that stage of the process, you can easily learn whether decision makers wish your report to include recommendations.

If you present an oral report, your recommendations will often be solicited even though you may have been directed to avoid such recommendations in writing. Be prepared to respond to such requests.

Final thoughts about Guideline 5

This final guideline may appear to involve substantial effort. After all, not only are two written reports to be authored, but an oral report is to be made as well. Any effort associated with reporting an evaluation study's results, however, will usually be well worth it. What good does it do to design and carry out a first-rate evaluation study if the results make little impact on the decision makers for whom it was originally conducted?

Reporting an evaluation's results should not be an afterthought. From the earliest days of the evaluation study, you should continually think about how the study's results can be most effectively communicated.

Although Guideline 5 does not directly address the topic of making recommendations regarding the decisions at issue, you will find that if decision makers request your recommendations, they will typically be influenced by your views. If you offer recommendations without being asked, however, your advice may be seen as presumptuous and may be rejected. Be guided by the decision makers' preferences.

Conclusion

These five guidelines are important to consider in designing and conducting your HIV education evaluation. They will also provide a set of criteria to use in deciding whether your planned evaluation of an HIV education program is likely to be successful.

Think of these guidelines as procedural decision-points. Although you will need to make other choices as an evaluator, these guidelines can function as a framework for the procedural steps you will follow as the evaluation occurs.

As stated at the outset, this treatment of educational evaluation is decidedly modest. By consulting the references listed in the Additional Reading section, you can achieve further insight into evaluative topics.

Five guidelines cannot transform a novice evaluator into an expert. Nonetheless, if you follow this booklet's guidelines when evaluating HIV education programs, you can be confident that your resulting evaluations will be superior to evaluations departing dramatically from the guidelines. In view of the threat represented by HIV and the certainty that more effective HIV education programs will help students avoid HIV infection, improvements in the evaluation of HIV education will be well worth the effort expended.

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HANDBOOK OVERVIEW

This booklet is part of a series of eight booklets included in the *Handbook for Evaluating HIV Education*. The handbook contains evaluation designs and measurement tools necessary to collect data on the basic program components of policy development, curriculum design, teacher training, and student outcomes. The eight booklets are listed below.

1. **Evaluating HIV Education Programs**
2. Developing and Revising HIV Policies
3. Appraising an HIV Curriculum
4. Evaluating HIV Staff Development Programs
5. Assessment Instruments for Measuring Student Outcomes: Grades 5-7
6. Assessment Instruments for Measuring Student Outcomes: Grades 7-12
7. Choosing and Using an External Evaluator
8. Reporting Results of HIV Education Evaluations

For further information on the use of these booklets, please contact your state HIV coordinator or your CDC project officer.

Developing and Revising HIV Policies

BOOKLET 2

DIVISION OF ADOLESCENT AND SCHOOL HEALTH
NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION
AND HEALTH PROMOTION
CENTERS FOR DISEASE CONTROL

DEVELOPING AND REVISING HIV POLICIES

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TABLE OF CONTENTS

Page

INTRODUCTION 1

AVAILABLE DOCUMENTS 2

Someone at School Has AIDS: A Guide to Developing Policies for Students and School Staff Members Who Are Infected with HIV 3

Effective AIDS Education: A Policymaker's Guide 3

Reducing the Risk: A School Leader's Guide to AIDS Education 4

Effective HIV Education in Urban Schools: A Policymaker's Guide 5

Responding to HIV and AIDS 5

The NSBA HIV and AIDS Resource Database 6

The AIDS School Health Education Subfile of the Combined Health Information Database (CHID) 6

Guidelines for Effective School Health Education to Prevent the Spread of AIDS 8

POLICY EVALUATION 8

CONCLUSION 9

APPENDICES:

A. Policymaking Process Checklist 11

B. Policymaking Content Checklist 13

C. Sample Policy Survey for Educators 21

Introduction

The growing problem of HIV and AIDS in schools and in society demands a reaction from educators. Sound educational policies regarding HIV and AIDS are a first, vital step in formulating an educational response to the disease. Many state and district officials have developed HIV policies to educate their communities about the disease, set a clear direction, and allay any public concern. These policies establish guidelines for decision making and action that teachers, principals, and other educators can follow when their schools are confronted with the issue of HIV. When schools and communities agree on these policies, they often avoid the confusion that can surround HIV and AIDS.

Three areas of concern are typically addressed by HIV policies: issues of education, issues regarding students and staff who are infected with HIV, and procedures for safely handling body fluids. Policies focusing on education typically address such issues as when and how to teach students about HIV and AIDS, the content of an HIV curriculum, staff preparation, and evaluation of the HIV education program. Policies focusing on people particularly address the confidentiality and rights of people who are infected. Policies focusing on infection control address proper methods of ensuring a safe environment for students and staff.

HIV policies that focus on education vary greatly from state to state, from detailed guidance to offering general guidelines for district educators to follow if they wish. Policies also need to be developed at the district level. HIV policies are most successfully developed with substantial community and health department involvement. Some states, in fact, require school districts to involve community members when establishing local HIV policies. As with state policies, district policies vary greatly, often reflecting the traditions and values of their community.

Although great variability can be found among state and local policies, sound HIV policies are built on common ground. Basic procedures should be followed in developing a policy to ensure that the policy, whether focused on education, people infected with HIV, or contact with body fluids, is effective. Certain content issues are consistently considered in district-level HIV education policies. Much of the content of policies for people with HIV are dictated by current medical knowledge as well as laws protecting individual rights. In addition, responsible policymakers will evaluate their HIV-related policies and revise them if necessary to make them more up to date and effective.

Several aids to policymakers are included in this booklet. Selected resources that provide detailed discussions of HIV policy development and content issues are summarized, and information for ordering them is provided. Two rating forms are provided at the end of this booklet that address issues related to (1) the policymaking process, and (2) policymaking content—that is, HIV education policies, policies regarding persons infected with HIV, and infection control policies. Although these rating forms appear to be prescriptive, they should be used with the understanding that policies among school districts may vary greatly due to overriding state policies, the districts' internal characteristics, and community influence. Also included at the end of this booklet is a sample survey asking teachers and administrators about the dissemination of a policy, their training regarding the policy, and their use of the policy.

Available Documents

Since policy development guidelines have been well stated in the following documents, they will not be restated here. To assist those who are either developing an HIV-related policy or revising an existing one, the following pages contain summaries of selected booklets and databases from organizations that have already addressed this topic. These resources provide detailed discussions of policy content and process issues.

Some of the materials summarized here are more relevant to HIV education-focused policies, while others are more applicable to people infected with HIV. Some of these materials deal primarily with infection control. Most of these materials contain bibliographies leading to other sources that may be helpful in revising or establishing policies. Note, however, that although these documents have been published relatively recently, some information may already be out of date. As a result, educators should have their policies reviewed by someone from their local health department who is knowledgeable about HIV and AIDS. Another possibility would be to check with the National Aids Hotline (800/342-2437) or the National AIDS Information Clearinghouse to ensure that policies are based on current information.

Someone at School Has AIDS: A Guide to Developing Policies for Students and School Staff Members Who Are Infected with HIV. Alexandria, VA: National Association of State Boards of Education, 1989. For additional information, write or call the National Association of State Boards of Education, 1012 Cameron Street, Alexandria, VA 22314 (703/684-4000).

Someone at School Has AIDS

Although this 35-page booklet was developed for state and local policymakers, it contains information of interest to anyone wanting to know more about HIV policies and how schools can best prepare for the impact of HIV and AIDS on their communities. The booklet contains a set of suggested policies related to students and staff members infected with HIV. More specifically, these policies speak to (1) general principles, (2) dealing with students or staff infected with HIV, (3) confidentiality, (4) testing, and (5) infection control. Each policy is followed by a discussion providing answers to questions readers may have about the policy. These policies were developed in 1988 and 1989 by a group of experts in law, medicine, public health, and education who were familiar with the issues surrounding HIV infection and AIDS. The experts were asked to develop policies for state and local school districts regarding students and school staff members who were infected with HIV. The suggested policies reflect this group consensus.

This booklet also contains a resource section discussing steps to take in developing an HIV-related policy, general principles for HIV education, relevant federal legislation on discrimination and protection for the handicapped, reporting of HIV infection, and crisis management. Two appendices contain information on ordering related publications and a separate bibliography of related references.

Effective AIDS Education: A Policymaker's Guide. Alexandria, VA: National Association of State Boards of Education, 1988. For additional information, write or call the National Association of State Boards of Education, 1012 Cameron Street, Alexandria, VA 22314 (703/684-4000).

This 36-page booklet challenges state policymakers to provide effective HIV education for staff and students and to develop comprehensive policies related to HIV and

Effective AIDS Education: A Policymaker's Guide

AIDS. It is divided into three parts. Section I describes the AIDS epidemic and discusses the risk for teenagers and the consequent need for education related to HIV and AIDS.

Section II deals with the challenge of providing an effective education program that will motivate young people to change their behaviors related to HIV infection. This section includes a brief description of several approaches that might be useful in changing behaviors, a discussion of the role of abstinence in HIV education programs, and discussions of the need for materials and programs developed especially for minority youth and for those who may be difficult to reach, such as runaways, young homosexuals, and IV drug users.

Section III focuses on the role of state policymakers in combatting HIV and AIDS. This section encourages state policymakers to expand their traditional leadership role of setting policies and providing funding to a more comprehensive role that includes creating a multifaceted state plan for AIDS, building public support for effective AIDS prevention education, and providing continuing attention to these issues. This booklet also contains a list of sources for more information.

Reducing the Risk: A School Leader's Guide to AIDS Education. Washington, DC: National School Boards Association, 1990. For additional information, write or call the National School Boards Association, 1680 Duke Street, Alexandria, VA 22314 (703/838-6722).

Reducing the Risk: A School Leader's Guide to AIDS Education

This 43-page booklet provides school leaders with information they need to make decisions and to provide the leadership necessary for effective HIV education in the nation's schools. It provides information not only about HIV education but also about ways to deal with possible adverse responses from the community faced with HIV infection in the schools. The booklet begins with information regarding the epidemiology of AIDS and documents the magnitude and threat of HIV infection, especially to young people. The booklet also stresses the need for HIV education and policies. Suggestions are offered to help policymakers overcome barriers to HIV education. Also included are a policy framework for HIV education and a discussion of issues that are important for making curricular and instructional decisions. The booklet concludes with a section containing resources for school officials to use in developing HIV education programs.

Effective HIV Education in Urban Schools: A Policymaker's Guide. Washington, DC: Council of the Great City Schools and National Association of State Boards of Education, 1991. For additional information, write or call the National Association of State Boards of Education, 1012 Cameron St., Alexandria, VA 22314 (703/684-4000) or the Council of the Great City Schools, 1413 K St. N.W., Suite 400, Washington, DC 20005 (202/371-0163).

Effective HIV Education in Urban Schools: A Policymaker's Guide

This 54-page booklet is intended to be a resource guide specifically for educators in urban school districts. The booklet is divided into three sections. Section I includes information about the HIV epidemic, a review of AIDS research, and a discussion of the need for HIV prevention education. In Section II, the components of effective HIV education programs are discussed with an emphasis on changing behavior through comprehensive school health programs, reaching youth in high-risk situations, and tapping community support and services.

The largest portion of the booklet, Section III, describes the elements of a district plan for preventing the spread of HIV infection. Six steps normally taken in developing a district plan for HIV prevention education are presented in this section. They include: building public support, creating a district policy and program, monitoring and evaluating the district program, enacting a district policy, developing a crisis action plan, and providing continuing attention to AIDS education. The booklet also contains ordering information for selected publications and a bibliography of related books, reports, and articles.

Responding to HIV and AIDS. Washington, DC: The National Education Association Health Information Network, 1992. For additional information, write or call The NEA Health Information Network, 1201 16th St. NW, Washington, D.C. 20036 (202/822-7570).

Responding to HIV and AIDS

This 40-page booklet provides basic information about AIDS and HIV and its transmission. It is the third handbook about the HIV epidemic developed for the National Education Association. The booklet includes sections on HIV antibody testing, proper methods for handling bodily fluids in the school setting, how infected people can be helped, and the processes of grief and mourning experienced at the death of a loved one. The booklet also contains national hotline numbers, hotline numbers for each state, and addresses and phone numbers for state and local HIV education liaisons.

The NSBA HIV and AIDS Resource Database. Alexandria, VA: National School Boards Association. For additional information, write or call the HIV and AIDS Education Project, NSBA, 1680 Duke St., Alexandria, VA 22314 (703/838-6754).

NSBA HIV and AIDS Resource Database

The NSBA HIV and AIDS Resource Database was developed by the National School Boards Association's HIV and AIDS Education Project to help policymakers and educators make informed decisions about HIV and AIDS policy and education issues. The database contains over 700 entries and is continuously updated. Database entries include state and local policies, curricula, articles, books, journals, and videotapes. Each entry includes an abstract, basic bibliographic information, information about the target audience, and a description of the type and subject of the material. Subjects that can be found in the database include HIV transmission modes, legal and policy issues, HIV prevention education, comprehensive health education, and community involvement. Hard copies of source materials are maintained by the HIV and AIDS Education project, and reproductions of many items are available upon request.

The AIDS School Health Education Subfile of the Combined Health Information Database (CHID). Atlanta, GA: Division of Adolescent and School Health of the Centers for Disease Control's Center for Chronic Disease Prevention and Health Promotion. CHID is available for online searching through MAXWELL ONLINE, BRS Information Technologies Division, 1200 Route 7, Latham, NY 12110 (800/289-4277).

Adolescent and School Health Resources: HIV and AIDS. Atlanta, GA: Division of Adolescent and School Health of the Centers for Disease Control's Center for Chronic Disease Prevention and Health Promotion, April 1990 and (update) January 1991. These written publications contain citations and abstracts of all of the resources entered into the AIDS School Health Education

Computer Database through January 1991. For additional information, write or call Bill Thomas, Centers for Disease Control, Technical Information Services Branch, Mailstop K-13, Atlanta, GA 30333 (404/488-5080) or Margaret Cleveland, Centers for Disease Control, Division of Adolescent and School Health, Mailstop K-31, Atlanta, GA 30333 (404/488-5372).

The AIDS School Health Education Subfile of the Combined Health Information Database (CHID)

The AIDS School Health Education Database can be accessed using a telecommunicating computer terminal or through libraries and information centers that subscribe to BRS. To access CHID using your own computer terminal, you need a subscription to BRS, a communications software package, and a modem.

The database includes educational materials and other relevant information on HIV infection and AIDS for educators to use in teaching children, youth, and college-aged students about HIV infection and AIDS. The 295-page publication, *Adolescent and School Health Resources: HIV and AIDS* (April 1990) and its 76-page January 1991 update contain citations and abstracts of the materials contained in the database. Citations and abstracts included in these two publications are listed in the following sections: audiovisuals; books and book chapters; brochures and pamphlets; journal articles; papers, speeches, and statements; reports; teaching guides and curricula; and other miscellaneous entries. Each citation contained in *Adolescent and School Health Resources: HIV and AIDS* and its supplement provides information on how the cited item can be ordered or obtained.

Guidelines for Effective School Health Education to Prevent the Spread of AIDS, Morbidity and Mortality Weekly Report: Supplement No. S-2, Vol. 37. Atlanta, GA: U.S Department of Health and Human Services, Public Health Services, Centers for Disease Control, Center for Health Promotion and Education, June 24, 1988. For additional information, write or call Centers for Disease Control, Division of Adolescent and School Health, Mailstop K-31, Atlanta, GA 30333 (404/488-5372).

This 14-page *MMWR* supplement provides educators with information they need to plan, implement, and evaluate their HIV prevention education efforts. The need for developing HIV education policies is emphasized. The docu-

Guidelines for Effective School Health Education to Prevent the Spread of AIDS

ment also stresses that HIV education should be locally determined and consistent with community values, and that state departments of education and health should work together with local school districts and departments of health in providing HIV education. The guidelines recommend that HIV education be provided at multiple grade levels, from early elementary to high school, as part of a comprehensive health education program. Specific guidelines are provided for the preparation of school personnel and the content to include in early elementary school, late elementary/middle school, and junior high/senior high school HIV education programs. In addition, recommendations are given for teacher qualifications, goals related to effective HIV education, curriculum time and resources, and program assessment.

Policy Evaluation

Many states and school districts already have HIV policies in place. Some of these policies are well-conceived documents that provide sound advice for teachers and administrators. They have provided thoughtful guidance in times of crisis and have helped provide quality HIV education to students. Other policies, however, may not have been as successful. Officials in school districts or states with preexisting HIV-related policies need to know if their policies are defensible in light of current knowledge, are understood by everyone who might need to follow them, are in the hands of everyone who might need to follow them, and have met the needs of the people affected by them. By systematically evaluating HIV policies, educators can see whether their policies are well conceived and have been effective. If the policies fall short of expectations, they can be improved through revision.

Three basic procedures can be used to evaluate an HIV-related policy. (1) The content of the policy and the process by which it has been developed can be judged against the recommendations provided in the policy guidance documents cited. (2) The policy can be reviewed by experts against current medical and legal knowledge that may have changed since the policy was enacted. (3) Users of the policy can be surveyed. The checklists in Appendices A and B can be used as tools for the first approach. Appendix C provides a sample survey of teachers and administrators that policymakers can use to gain information from users of the policy (the third approach). Policymakers can judge whether or not the policy has met their expectations based on information they gain from this survey. In addition to using the resources contained in this booklet, policymakers can periodically review their policy from a legal and medical standpoint with local experts (the second approach). If after collecting information using these three tactics the policy is found to be lacking in some way, policymakers should consider revising the policy.

Conclusion

The development of HIV policies is a critical first step for educators fighting the battle against AIDS. Sound policies lead to successful HIV prevention programs and ensure effective responses from school personnel in situations ranging from a child cutting a finger to a community in crisis. Each of the policymaking procedures and content issues discussed in the documents cited in this booklet should be considered in developing or reviewing an HIV policy. Although all of these procedures and issues should optimally be followed or addressed, they may not be applicable to a school district because of overriding state policies, the district's internal characteristics, or the local community's influence. These influences should be thoughtfully acknowledged when rating a policy against the procedures and content issues addressed in the checklists in this booklet. Both the development and evaluation of a policy require an understanding of many factors and a sensitivity to varied points of view. With flexibility in mind and policymaking and evaluation tools at their disposal, policymakers should find both developing and improving their policies a rewarding experience.

APPENDIX A

Policymaking Process Checklist

1. Gathered updated and pertinent HIV information and contacted experts.

YES NO UNCLEAR

2. Formed a policy-development committee representing diverse community and school interests.

YES NO UNCLEAR

3. Provided the committee with updated HIV information and ample opportunity to share their opinions.

YES NO UNCLEAR

4. Committee reached consensus on most issues to be addressed in the policy.

YES NO UNCLEAR

5. Sought all committee members' suggestions for revision of the initial policy draft.

YES NO UNCLEAR

6. Had policy approved by committee and adopted by school officials.

YES NO UNCLEAR

7. Provided thorough information to the public about the policy.

YES NO UNCLEAR

8. Provided staff training regarding HIV policies.

YES NO UNCLEAR

9. Devised a plan for the periodic review of HIV-related policies.

YES NO UNCLEAR

APPENDIX B

Policymaking Content Checklist

HIV Education Policy

1. Thorough HIV education is included as a part of a more comprehensive school health education program.

   YES NO UNCLEAR

2. HIV education is integrated into other subject areas.

   YES NO UNCLEAR

3. HIV education is required of students before advancing to another grade level or graduating.

   YES NO UNCLEAR

4. HIV education is taught in elementary school through high school.

   YES NO UNCLEAR

5. HIV education is designed to help students acquire essential knowledge to prevent HIV infection at each appropriate grade.

   YES NO UNCLEAR

6. HIV education describes the benefits of abstinence for young people.

   YES NO UNCLEAR

7. HIV education is designed to help teenage students avoid specific types of behavior that increase the risk of becoming infected with HIV.

   YES NO UNCLEAR

8. HIV education is taught by regular classroom teachers in elementary grades and by qualified health education teachers or other similarly trained personnel in secondary grades.

YES NO UNCLEAR

9. Sufficient program development time, classroom time, and educational materials are provided for HIV education.

YES NO UNCLEAR

10. Guidance regarding appropriate HIV topics, instructional materials, and strategies are provided.

YES NO UNCLEAR

11. Adequate training about AIDS is provided for school administrators, teachers, nurses, and counselors—especially those who teach about AIDS.

YES NO UNCLEAR

12. The outlined staff development program has all of the characteristics provided in Guideline 2 of *Evaluating HIV Staff Development Programs.*

YES NO UNCLEAR

13. Parents, teachers, students, and community representatives are involved in developing, implementing, and assessing HIV education policies and programs.

YES NO UNCLEAR

14. Parent or guardian permission for student participation in HIV education is required.

YES NO UNCLEAR

15. A plan for the evaluation of the HIV education program is specified.

YES NO UNCLEAR

Addressing the Needs of Persons Infected with HIV

1. Specific procedures to meet the needs of persons infected with HIV are simple, standard, and clearly defined.

   YES NO UNCLEAR

2. A breech of confidentiality is highly unlikely given the confidentiality procedures established by the policy.

   YES NO UNCLEAR

3. Great care is taken to protect against discrimination of a student or staff member infected with HIV.

   YES NO UNCLEAR

4. There is little or no disruption to the school schedule, responsibilities, or job environment of a student or staff member infected with HIV.

   YES NO UNCLEAR

5. A plan for the periodic review of the health status of a person infected with HIV is addressed.

   YES NO UNCLEAR

6. Specific procedures are clearly defined for appealing HIV-related district decisions or policies.

   YES NO UNCLEAR

7. The district contact person for staff infected with HIV and parents of students infected with HIV is clearly identified.

   YES NO UNCLEAR

Infection Control Policy

1. Procedures for cleaning up body fluids and handling blood are clearly defined in the policy.

   YES NO UNCLEAR

2. Training of all staff in infection-control procedures is required.

   YES NO UNCLEAR

Appendix C

Sample Policy Survey for Educators

Assessment Focus: Policy dissemination and educators' reactions to an HIV education policy and infection control procedures

General Description

This sample five-page form measures the extent of HIV policy dissemination to educators and their reactions to the policy.

Rationale

Teachers and administrators who utilize a policy in carrying out their duties can provide insights regarding the usefulness of the policy that are not immediately apparent to policymakers. Policymakers often find this information useful in organizing policy dissemination efforts and revising policy statements. Educators can offer the most useful information after they have attempted to implement what they learned in staff development sessions regarding the policies. Therefore, a survey such as that provided here should not be distributed to participants at the conclusion of a staff development session. Instead, surveys should be circulateed to participants after enough time has passed to expect them to use the policies. The survey can be distributed to a representative sample of teachers and administrators or to all teachers and administrators in the district.

Scoring Procedures

The contents of a policy evaluation form should be customized to reflect a particular district's policies and related training. Scoring, therefore, would be based on the particulars of the form being used. Because HIV crisis action plans are carried out by a very small number of individuals close to the superintendent of a district, questions regarding a crisis action plan probably would not appear on a general teacher or administrator survey.

POLICY SURVEY FOR EDUCATORS

The purpose of this survey is to find out how helpful the district's HIV and AIDS policies are to teachers and students. The information that you provide will be used to improve the policies and the training efforts associated with them.

Please do not put your name on this form. Your answers will be anonymous. When you have completed this survey, return it in the enclosed stamped self-addressed envelope.

1. What is your primary position? (Circle one.)

   A. Teacher
   B. Administrator
   C. Nurse
   D. Counselor
   E. Other

2. Are you familiar with any of the district's policies related to HIV and AIDS? (Circle one.)

   YES NO

If no, please stop here and return the survey. Thank you.

3. Do you have a copy of any of the following HIV policy statements? (Circle all that apply.)

   A. Infection Control Procedures
   B. HIV Education Policy
   C. Policy regarding Students and Staff Members Infected with HIV
   D. HIV Crisis Action Plan

Please go on to the next page. ⇒

HIV EDUCATION POLICY

This section of the survey asks questions about the district's HIV education policy and the staff development efforts related to that policy.

4. Have you attended the district's educator training for HIV education? (Circle one.)

YES NO

If you have not attended the training session, please go to question 8.

5. During the training session, were the district's HIV policies presented and explained? (Circle one.)

YES NO NOT SURE

6. What aspects of the district's HIV education policy should have been treated more extensively in the training?

7. What additional policy-related topics should have been included in the training?

Please go on to the next page. ⇒

POLICY ADDRESSING THE NEEDS OF PERSONS INFECTED WITH HIV

This section of the survey asks questions about the district's procedures for addressing the needs of persons infected with HIV.

8. Have you received training in how to meet the needs of students and staff members infected with HIV? (Circle one.)

   YES NO

9. Do you have access to materials that describe confidentiality procedures for students and staff infected with HIV? (Circle one.)

   YES NO NOT SURE

10. During the past year, did you encounter a situation that involved providing support to a student or staff member infected with HIV? (Circle one.)

    YES NO

11. What changes would you recommend in the procedures or the training you received in providing support to students or staff members infected with HIV?

INFECTION CONTROL PROCEDURES

This section of the survey asks questions about the district's established procedures for cleaning up blood and other body fluid spills in the event of an accident or illness.

12. Have you received training in how to avoid HIV and other infections when handling body fluids? (Circle one.)

    YES NO

Please go on to the next page. ⇒

13. If you wanted to correctly follow the district procedures to clean up a child's nose bleed, would you need to review the written procedures before cleaning away the blood? (Circle one.)

DEFINITELY YES	PROBABLY YES	NOT SURE	PROBABLY NOT	DEFINITELY NOT

14. Does your school have the materials needed to correctly follow the district infection control procedures? (Circle one.)

YES	NO	NOT SURE

If not, what materials are you lacking?

____

____

____

15. Do you have quick access to the materials needed to correctly follow the district infection control procedures? (Circle one.)

YES	NO	NOT SURE

If not, what is limiting your access?

____

____

____

16. During the past year, did you encounter a situation that involved you cleaning up blood or other body fluid spills at school? (Circle one.)

YES	NO

Please go on to the next page. ⇒

17. During the past year, did you use the district infection control procedures? (Circle one.)

YES NO

18. If you answered YES to question 17, how useful did you find the procedures in the situation(s) you faced? (Circle one.)

A. Very useful
B. Somewhat useful
C. Not at all useful

19. What changes would you recommend in the procedures or the training you received to make them more useful to you in handling blood or other body fluid spills?

____

____

____

Thank you for completing this survey.

HANDBOOK OVERVIEW

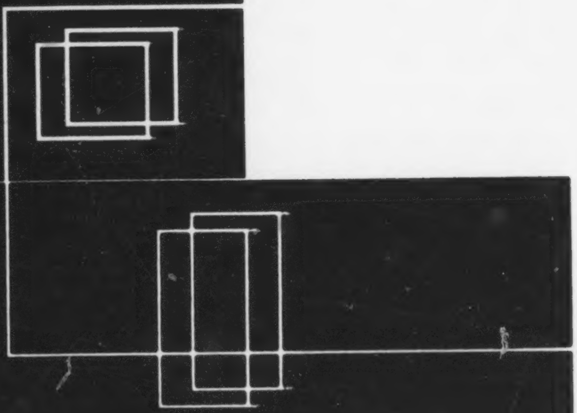
This booklet is part of a series of eight booklets included in the *Handbook for Evaluating HIV Education*. The handbook contains evaluation designs and measurement tools necessary to collect data on the basic program components of policy development, curriculum design, teacher training, and student outcomes.
The eight booklets are listed below.

1. Evaluating HIV Education Programs
2. Developing and Reviewing HIV Policies
3. Appraising an HIV Curriculum
4. Evaluating HIV Staff Development Programs
5. Assessment Instruments for Measuring Student Outcomes: Grades 5-7
6. Assessment Instruments for Measuring Student Outcomes: Grades 7-12
7. Choosing and Using an External Evaluator
8. Reporting Results of HIV Education Evaluations

For further information on the use of these booklets, please contact your state HIV coordinator or your CDC project officer.

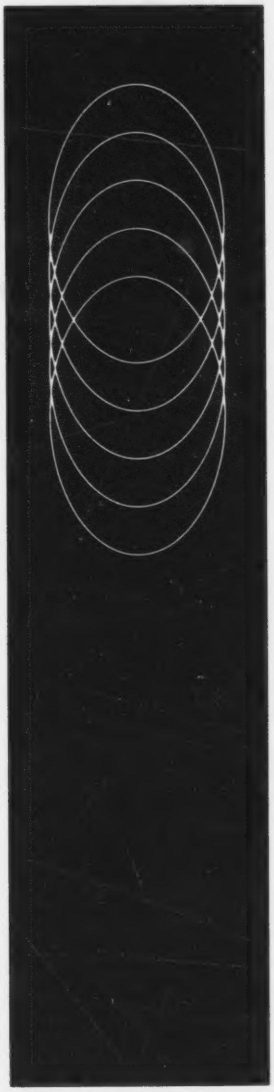
BEST COPY AVAILABLE

Appraising an HIV Curriculum



BOOKLET 3

DIVISION OF ADOLESCENT AND SCHOOL HEALTH
NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION
AND HEALTH PROMOTION
CENTERS FOR DISEASE CONTROL



APPRAISING AN HIV CURRICULUM

W. James Popham
Elizabeth A. Hall

This booklet was prepared by IOX Assessment Associates under Contract No. 200-88-0683 with the Division of Adolescent and School Health, Centers for Disease Control.

TABLE OF CONTENTS

Page

INTRODUCTION 1

GUIDELINES

Guideline 1: The content of an HIV education program should be chosen after considering the current status of students 1

Guideline 2: A preliminary appraisal of an HIV curriculum's likely success can be determined by reviewing the curriculum's internal characteristics 2
- Instructional psychology 3
- Functional knowledge 4
- Vulnerability perceptions 5
- HIV-related attitudes 6
- Interpersonal skills 7
- Involvement of parents and guardians 8
- Adequate duration 8
- A checklist 9

Guideline 3: Attention should be given to the degree to which the HIV curriculum has been implemented as planned 9

Guideline 4: An HIV curriculum should be evaluated primarily on the basis of its impact on students 10

CONCLUSION 11

SELECTED REFERENCES REGARDING SOCIAL SCIENCE BEHAVIOR-CHANGE THEORIES 13

JUDGING AN HIV CURRICULUM BY ITS INTERNAL CHARACTERISTICS 15

SAMPLE CURRICULUM IMPLEMENTATION SURVEY 19

Introduction

Perhaps the most important element of any HIV education program is the curriculum it employs. The curriculum consists of the knowledge and skills to be emphasized in the program as well as the instructional activities chosen to promote students' mastery of that knowledge and those skills. The curriculum of an HIV education program, in short, deals with what gets taught and how it gets taught.

If a school district's educators decide to install a new HIV education program, or if they wish to review the quality of an existing HIV education program, the caliber of the program's curriculum is pivotal. In this booklet, a set of four guidelines will be offered to educators who wish to scrutinize a proposed or existing curriculum for HIV education.

When appraising a curriculum for an HIV education program, educators should be sure that the curriculum is consistent with district, local, and state policies regarding HIV or sexuality education. In addition, district officials may wish to establish a curriculum review committee consisting of teachers, administrators, nurses, health department staff, other staff with expertise in health education, parents, students, and community leaders. Such a committee can be called upon to review the curricular content and determine the degree to which it is consonant with local community values.

Guideline 1: The content of an HIV education program should be chosen after considering the current status of students.

Analyze students' needs.

The history of education is replete with examples of instruction designed to promote students' mastery of knowledge that the students already possessed. The teachers in those instances simply misjudged what the students already knew. Similarly, there are numerous examples of instructional efforts that failed to provide students with important knowledge or skills that they did not possess. In this second type of curricular error, the teachers erroneously assumed that the students knew content that, in fact, they did not.

The way to avoid these two curriculum-planning errors is to determine the objectives and curricular content of an HIV education program after assessing what the preinstruction status of students actually is. By identifying students' preinstruction status regarding knowledge, skills, attitudes, and risk behaviors, the architects of HIV education programs can make sure they incorporate needed content while, at the same time, avoiding redundant content.

It is really quite simple to get a fix on students' preinstruction status with respect to potential content for an HIV curriculum. All we have to do is assess the students with measurement devices that focus on the content of most interest, for example, students' HIV-related knowledge, attitudes, skills, and behaviors. Other booklets in this handbook provide a variety of appropriate assessment instruments for students in grades 5-7 and grades 7-12.

It is obvious that students differ from community to community with respect to their HIV-related knowledge, attitudes, skills, and behaviors. This initial guideline emphasizes the importance of designing an HIV curriculum for the specific students to be taught.

It is also possible to use more qualitatively focused approaches to gain an idea of students' current HIV-related knowledge, skills, attitudes, and behaviors. Individual interviews or focus group interviews can provide illuminating insights. Ideally, such qualitative approaches would be used in conjunction with more quantitatively oriented assessment approaches such as the self-report instruments found elsewhere in the handbook.

Once a clear estimate is garnered of students' current status, then more appropriate instructional objectives can be identified for the program as well as a set of instructional procedures to accomplish those objectives. This first guideline emphasizes the need to determine what the particular needs of the students are before selecting or designing an HIV curriculum.

Guideline 2: A preliminary appraisal of an HIV curriculum's likely success can be determined by reviewing the curriculum's internal characteristics.

In the final analysis, an HIV curriculum's quality must be judged by its impact on students. However, before that evaluation of the curriculum takes place, it is possible to make a preliminary evaluation of a given HIV curriculum based exclusively on the curriculum's internal characteristics. If a curriculum is found wanting, it is still possible that when implemented it might be successful. But it's not likely. It is also possible that an HIV curriculum that contains a host of positive internal characteristics may not prove effective when implemented. However, this scenario is less likely.

Judge the program's characteristics to determine its probable effectiveness.

There are seven internal characteristics that an HIV curriculum may or may not embody. The seven internal characteristics deal with (1) instructional psychology, (2) functional knowledge, (3) vulnerability perceptions, (4) HIV-related attitudes, (5) interpersonal skills, (6) involvement of parents and guardians, and (7) adequate duration.

These internal characteristics are based on (1) findings drawn from research dealing with other aspects of health education and (2) the experiences of educators in providing HIV education programs during the past several years. Because the seven characteristics are based on empirical evidence, educators who adhere to these characteristics can increase the likelihood that their HIV education program will influence the behaviors that place students at risk of HIV infection.

Instructional psychology: An appropriate HIV curriculum adheres to sound principles of instructional psychology.

As with any educational program, HIV education should be well grounded in the fundamentals of instructional psychology. During the past several decades, instructional psychologists have assembled an effective array of research-based principles that will tend to yield positive results for students. A number of correlational and experimental studies have shown, for example, that students who receive more "time on task" will outperform those who do not. Thus, if an HIV education program attempts to promote students' acquisition of interpersonal skills such as the ability to resist peer pressure without sacrificing friendships, the program's curriculum must provide ample opportunities for the students to practice these skills.

A teacher who simply talks at students is likely to have little impact on the students' acquisition of knowledge, skills, or attitudes. On the other hand, a teacher who provides students not only with clear explanations but also with sufficient amounts of relevant practice is likely to promote positive changes in those students.

Most health educators are familiar with the importance of such principles as (1) communicating instructional objectives to students in understandable language, (2) activating students' prior knowledge by providing reviews of such knowledge and skills, (3) modeling desired behavior so that students clearly understand what is sought, (4) providing students with closely monitored guided practice, (5) supplying ample independent practice when students are ready for such practice, (6) providing students with immediate knowledge of results regarding their efforts, (7) asking questions and dealing with responses in a manner that maximizes students' participation, and (8) summarizing main points from lessons or longer instructional sequences. Although by no means exhaustive, instructional principles such as these can substantially boost the effectiveness of an instructional sequence. HIV educators who are not conversant with such instructional principles should strive to become so. Regardless of the instructional procedures being employed (lectures, discussions, small group work, etc.), the application of proven principles of instruction will typically enhance the effectiveness of any HIV education program. HIV education programs that fail to incorporate sound instructional principles are almost certain to be ineffective.

Functional knowledge: An appropriate HIV curriculum promotes students' functional knowledge about HIV.

Practical information about HIV, such as the methods of HIV transmission and the personal consequences of AIDS and HIV infection, is referred to as *functional* knowledge. *General* HIV knowledge, on the other hand, consists of information such as how HIV affects the immune system, the history of AIDS, or information about the global AIDS pandemic. General HIV knowledge is not the essential knowledge that students must acquire to prevent becoming infected with HIV. Functional knowledge about how HIV is and is not transmitted, however, will help students recognize high-risk behaviors and can provide the information base students need to avoid these behaviors. Therefore, the inclusion of functional knowledge should be considered an integral part of any HIV curriculum.*

Functional knowledge about HIV transmission should be comprehensive enough to allow students to distinguish facts from myths about how HIV is transmitted. Information identifying risk behavior and ways of not becoming infected with HIV should address the broad range of behavior exhibited by young people. HIV curricula should be developed in ways that will enable and encourage young people who have not engaged in sexual intercourse or who have not used illicit drugs to continue to abstain

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*Recommendations for suitable content for HIV education programs, according to three grade-ranges is described in Centers for Disease Control, Guidelines for effective school health education to prevent the spread of AIDS, *MMWR* 1988; *37*(S-2).

from both activities. For young people who have engaged in sexual intercourse or have injected illicit drugs, school programs should enable and support them in abstaining from such behavior in the future. For young people who are unwilling to adopt the most effective approach to eliminating their risk of HIV infection, school systems, in consultation with local review panels, should provide information and skills education on preventive types of behavior that should be practiced by persons with an increased risk of acquiring HIV infection. These include (1) using a latex condom with spermicide if they engage in sexual intercourse, (2) not sharing needles or other injection equipment, (3) seeking treatment for drug addiction, and (4) seeking HIV counseling and testing if HIV infection is suspected.

To reiterate, this second internal characteristic focuses on the importance of including the kind of knowledge in an HIV curriculum that is likely to influence students' HIV-risk behaviors. To the extent that an HIV curriculum promotes general rather than functional knowledge, students' attention to behavior-relevant knowledge may be diminished.

Vulnerability perceptions: An appropriate HIV curriculum helps students realistically appraise their personal vulnerability regarding HIV infection.

An appropriate HIV curriculum should provide students not only with knowledge but also with motivation to avoid engaging in high-risk behaviors. Students will be more motivated to change their behavior if they believe they are personally vulnerable to HIV infection. The curriculum should first make students aware, as clearly and directly as possible, of the risks of HIV infection for teenagers and the consequences of becoming infected. The curriculum should then include lessons that enable students to assess their own risk of HIV infection and to understand the social and health consequences of their participation in HIV-risk behaviors. Sufficient instructional energy should be committed to this topic so that students will sense their personal vulnerability to HIV infection.

Students should be particularly discouraged from perceiving AIDS as a disease afflicting only other people (for example, homosexual males, sexually promiscuous adults, or users of injected drugs). Because of the lengthy latency period associated with HIV, students may have encountered few if any teenagers who actually have AIDS. As a consequence, many students improperly assume that AIDS is "somebody else's" disease. An appropriate HIV curriculum will address this issue directly enough to help students accurately perceive their own HIV at-risk status.

Among the instructional strategies that can be employed to promote more realistic perceptions of students' HIV-related vulnerability are (1) written descriptions or videotaped accounts of young people who have become infected with HIV, (2) panel presentations by peers, particularly those who are familiar with friends or family members infected with HIV, and (3) presentations by persons with AIDS who could personalize the threat of HIV infection for students.

An HIV education curriculum that fails to devote attention to students' perceived vulnerability to HIV infection is not likely to influence students' HIV-risk behaviors.

HIV-related attitudes: An appropriate HIV curriculum promotes positive attitudes toward methods of avoiding HIV-risk behaviors.

An appropriate HIV curriculum should foster attitudes that include (1) confidence in one's ability to recognize and avoid high-risk situations and (2) the disposition to set positive goals and resist both social pressure and personal temptations to deviate from those goals. Curricular material that promotes sexual abstinence should be included. Because not all students, particularly at the upper grade levels, will be sexually abstinent, curricular content dealing with condom use should also be provided. Finally, curricular materials should be used that endorse abstinence from intravenous drug use or other forms of needle sharing.

Although students' attitudes are generally believed to play a prominent role in modifying their behaviors, many instructional programs give little, if any, attention to promoting student attitudes conducive to the reduction of HIV risk. One cannot assume that students' attitudes will somehow change as a consequence of more cognitively oriented instructional activities. Instead, empirical evidence indicates that meaningful shifts in attitudes must be systematically addressed during an instructional program.

Attitudinally oriented instructional objectives should be identified in advance for particular lessons (or series of lessons). Instructional activities might be designed, for example, to help develop more favorable attitudes toward delaying the onset of sexual activities. Because modeling has been shown to be a potent influencer of one's attitudes, it may be helpful to show films or videotapes of teenagers who advocate (1) abstinence from sexual intercourse, (2) abstinence from drug use, or (3) the use of condoms by those who are sexually active. Similarly, because peer values often influence the attitudes of teenagers, student discussions regarding the perils of certain HIV-risk behaviors can sometimes modify students' risk-related attitudes.

Students' perceptions can sometimes prove useful when educators attempt to modify HIV-related attitudes. Student misperceptions of peer behavior are widespread. Adolescents often overestimate, for example, the extent to which other adolescents consume alcohol, use drugs, and engage in sexual activities. Because young people behave, at least in part, as a consequence of their inaccurate perceptions of peer behavior, it is useful to provide estimates of actual peer behavior from regional or national surveys. Younger teenagers can be made aware that the majority of students their age are not sexually active, while older teenagers can be given behavior estimates indicating that there are now increasing percentages of sexually active adolescents who use condoms. Such reality appraisals can be useful in shifting students' attitudes regarding HIV infection.

Although people's attitudes are influenced by a variety of factors, and although appropriate HIV-related attitudes may be formed serendipitously by students during an HIV education program, such attitudinal shifts should not be left to chance. Because students' attitudes toward HIV-risk behaviors are important determinants of students' actual behaviors, those attitudes must be seriously addressed in the curriculum.

Interpersonal skills: An appropriate HIV curriculum emphasizes interpersonal skills relevant to students' avoidance of HIV-risk situations.

Ample evidence demonstrates that health education programs that teach students the interpersonal skills (e.g., refusal skills and communication skills) needed to avoid risk situations have a greater likelihood of modifying students' subsequent risk-related behaviors than programs in which such skills are not promoted. Relevant interpersonal skills for HIV education include methods for identifying social situations that can place students at risk of HIV infection, avoiding such situations, escaping from them, and taking protective measures when students are otherwise unable or unwilling to escape them.

Because of the importance of these interpersonal skills to students' ultimate avoidance of HIV infection, the skills must be clearly explained and effectively modeled. Moreover, as previously indicated, students must receive enough guided and independent practice to master these social skills and be able to transfer them to real-life situations.

For the promotion of students' interpersonal skills, an instructional sequence such as the following might be appropriate: (1) describe the skill, (2) model the skill, (3) provide guided practice in using the skill, (4) provide independent practice in using the skill, and (5) encourage use of the skill in real-world settings.

The acquisition of a skill such as declining a friend's invitation to take part in risky behaviors without alienating the friend does not take place instantly. It takes substantial practice to become adept in the use of interpersonal skills. Thus, an appropriate HIV education curriculum should provide extended opportunities for students to understand, rehearse, practice, and transfer their HIV-related interpersonal skills.

Involvement of parents and guardians: An appropriate HIV curriculum includes activities to involve parents and guardians in the learning process.

Well-designed HIV curriculum materials should provide concrete ways to involve parents and guardians in ensuring that their child avoids HIV infection. Parents and guardians are typically the persons most concerned about the health and well-being of their child. Given the opportunity, they can add substantially to the efforts of the school in encouraging their child to avoid HIV-risk behaviors. Further, because HIV instruction must deal with sensitive and value-laden topics such as sexual behaviors, parents are in the best position to discuss their values and expectations.

Involvement of parents and guardians can take numerous forms such as homework assignments in which students watch an HIV-relevant program or read information about HIV infection and discuss the material with their parents and guardians. Parents and guardians can also be provided with materials that can help them to initiate discussions with their child about HIV prevention.

Adequate duration: An appropriate HIV curriculum is of sufficient duration for students to gain the knowledge and skills necessary to change their HIV-risk behaviors.

Studies have shown that meaningful changes in students' behaviors can rarely be brought about by short-duration instructional programs. Although educators may be able to provide students with knowledge in an hour or two of instruction, behavioral modification is seldom possible in such a short time.

No definitive research evidence has established the minimum length of an effective HIV education program. However, the results of investigations in other health-related areas suggest that an instructional program must last closer to 12-15 hours than to 1-3 hours to have a realistic chance to modify students' behavior.

If HIV education is included as part of a comprehensive school health curriculum emphasizing the acquisition of interpersonal skills, then fewer instructional hours need be committed specifically to HIV. Ideally, once the initial HIV education program is offered, periodic booster sessions should be carried out at later grade levels.

This seventh characteristic is applicable to a variety of learning outcomes that we wish our students to achieve. Students don't learn how to do their multiplication tables in a few hours or how to compose essays in a single day. It takes instructional time to accomplish worthwhile instructional outcomes.

A checklist

The seven characteristics presented in this second guideline are intended to provide HIV educators with a set of criteria against which to gauge the likely effectiveness of an HIV curriculum. The more fully these characteristics are embodied in the curriculum for an HIV education program, the greater the likelihood of the program's success.

One appropriate way to view the guidelines is to regard them as a set of checkpoints to consider when judging the quality of an extant HIV curriculum or one under development. To assist HIV educators in reviewing the internal characteristics of their curricula, a rating form is provided on page 15.

Guideline 3: Attention should be given to the degree to which the HIV curriculum has been implemented as planned.

In many instances a first-rate curriculum may have been created, yet when actually implemented, it appears ineffectual. The curriculum that takes place in the classroom, in such cases, is frequently a far cry from what had been contemplated by its architects. The HIV curriculum that has been planned may not be the HIV curriculum that is delivered in the classroom. Thus, this third guideline suggests that serious attention must be given to the fidelity of curricular implementation. Careful efforts should be devoted to the determination of how well the curriculum was actually implemented.

Although it is possible to implement this guideline in informal ways, such as by an evaluator's occasionally visiting classrooms or speaking with teachers, there is much to be said for approaching the curricular implementation task more systematically.

Determine how the program was delivered.

A survey is provided on page 19 to illustrate how someone might poll teachers to see if their implementation of an adopted curriculum was suitable. Because the illustrative survey is tied to a specific, albeit fictional, HIV curriculum, it would be necessary to particularize any such survey so that it deals with the curriculum involved.

Although planned curricula are never implemented perfectly, a judgment must be made about whether the curriculum was implemented with reasonable fidelity. Surveys such as the one included at the end of this booklet and unannounced observations of teachers' actual classroom instruction can be helpful in making such a judgment.

In too many instances it is determined that an educational program has been unsuccessful, yet the cause of that failure is unclear. Is it a deficiency in the curriculum itself or a deficiency in the way that the curriculum was implemented? If this guideline is followed, it will be possible to answer that question accurately.

Guideline 4: An HIV curriculum should be evaluated primarily on the basis of its impact on students.

Judge HIV education by its effects.

Although Guideline 2 emphasized the importance of appraising the internal characteristics of an HIV curriculum in order to form a preliminary estimate of the curriculum's likely effectiveness, this fourth guideline reminds us that, in the end, the consequences of a curriculum's usage must determine the curriculum's effectiveness.

Thus, attention must be given to ascertaining the effect of an HIV curriculum on students' knowledge, attitudes, skills, and behaviors. In the initial booklet in this handbook, *Evaluating HIV Education Programs*, suggestions are offered for gauging the impact of an HIV curriculum on students.

Conclusion

The appraisal of HIV curricula helps assure that school-based HIV education programs are delivered in the most effective and up-to-date manner possible. In reviewing HIV prevention curricula, school personnel together with local review panels should evaluate aspects of the curriculum that (1) address the identified needs of the students within the schools, communities, or regions; (2) examine the quality and completeness of the curriculum's components (i.e., instructional principles, functional knowledge, self-perceptions, attitudes, involvement of parents and guardians, skills, and duration); (3) determine the degree of fidelity between the curriculum and its application in the classroom; and (4) assess the impact of the curriculum on students' knowledge, attitudes, and behavior.

Selected References Regarding Social Science Behavior-Change Theories

A number of social science behavior-change theories are particularly relevant to health education. The curriculum appraisal guidelines presented in this booklet reflect important dimensions of several of these theories. Prominent among these are the social learning/social cognitive model, the theory of reasoned action, the health belief model, the transtheoretical model, the precede-proceed model, and protection motivation theory. Because these theoretical constructs provide insights about how and why people change their health behaviors, they can prove helpful in the fashioning of appropriate HIV curricula. The following is a list of further readings regarding these six behavioral models.

Social Learning/Social Cognitive Model

Bandura, A. (1986). *Social foundations of thought and action.* Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A. (1989). Self-efficacy mechanism in physiological activation and health-promoting behavior. In J. Madden, S. Matthysse, & J. Barchas (Eds.), *Adaptation, learning and affect.* New York: Raven Press.

Bandura, A. (1990). Perceived self-efficacy in the exercise of control over AIDS infection. *Evaluation & Program Planning 13*(1), 9-17.

Bandura, A. (1991). Social cognitive theory of self-regulation. *Organizational Behavior & Human Decision Processes, 50*(2), 248-287.

Theory of Reasoned Action

Ajzen, I. (1988). *Attitudes, personality, and behavior.* Dorsey Press: Chicago.

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior & Human Decision Processes, 50*(2), 179-211.

Fishbein, M. & Ajzen, I. (1975). *Belief, attitude, intention, and behavior: An introduction to theory and research.* Reading, MA: Addison-Wesley.

Health Belief Model

Becker, H.M. (1974). *The health belief model and personal health behavior.* Thorofare, NJ: Slack.

Becker, H.M., & Rosenstock, I.M. (1987). Comparing social learning theory and the health belief model. In W.B. Ward (Ed.), *Advances in health education and promotion* (Vol. 2, pp. 245-249). Greenwich, CT: JAI Press.

Brown, L.K., DiClemente, R.J., & Reynolds, L.A. (1991). HIV prevention for adolescents: Utility of the Health Belief Model. *AIDS Education & Prevention, 3*(1), 50-59.

Montgomery, S.B., Joseph, J.G., Becker, M.H., & Ostrow, D.G. (1989). The health belief model in understanding compliance with preventive recommendations for AIDS: How useful? *AIDS Education & Prevention, 1*(4), 303-323.

Transtheoretical Model

Prochaska, J. (1991). What causes people to change from unhealthy to health enhancing behavior? *Cancer Prevention, 2*, 30-34.

Prochaska, J. & DiClemente, C. (1986). Toward a comprehensive model of change. In W. Miller & N. Heather (Eds.), *Addictive behaviors: Processes of change* (pp. 4-27). New York: Academic Press.

Prochaska, J. & DiClemente, C. (1986). The transtheoretical approach. In J. Norcross (Ed.), *Handbook of eclectic psychotherapy* (pp. 163-200). New York: Brunner/Mazel.

Precede-Proceed Model

Green, L. & Kreuter, M.W. (1991). *Health promotion planning: An educational and environmental approach.* Mountain View, CA: Mayfield Publishing.

Protection Motivation Theory

Rippetoe, P.A. & Rogers, R.W. (1987). Effects on components of protection motivation theory on adaptive and maladaptive coping with health threat. *Journal of Personality & Social Psychology, 52*, 596-604.

Rogers, R.W. (1983). Cognitive and physiological process in fear appeals and attitudes change: A revised theory of protection motivation. In J.R. Cacioppo & R.E. Petty (Eds.), *Social psychology: A sourcebook* (pp. 153-176). New York: Guilford Press.

Judging an HIV Curriculum by Its Internal Characteristics

Curriculum under consideration: ______________________________

____

1. Instructional Psychology

Clearly adheres to sound instructional principles	Embodies few principles drawn from instructional psychology

2. Functional Knowledge

Emphasizes knowledge apt to influence one's risk behaviors	Emphasizes general, less personally useful HIV-related knowledge

3. Vulnerability Perceptions

Includes content/activities designed to increase students' perceptions of their personal vulnerability to HIV	Gives little or no attention to increasing accuracy of students' perceptions of their vulnerability to HIV

4. HIV-Related Attitudes

Includes content/activities designed to foster appropriate HIV-related attitudes	Gives little or no attention to the fostering of appropriate HIV-related attitudes

5. Interpersonal Skills

Emphasizes student acquisition of interpersonal skills related to HIV-risk avoidance	Places little or no emphasis on the promotion of students' HIV-related interpersonal skills

6. Involvement of Parents and Guardians

Provides concrete activities to involve parents and guardians in HIV prevention education	Gives little or no attention to involving parents and guardians in instructional activities

7. Adequate Duration

At least 12-15 hours of instruction provided	Only 1-3 hours of instruction provided

SAMPLE CURRICULUM IMPLEMENTATION SURVEY

(This sample form, based on a fictitious HIV curriculum, would need to be modified to match the particular curriculum being appraised.)

DIRECTIONS: Each of the 6 lessons included in the *HIV Skills Curriculum* are listed below. Please indicate (1) which lessons you taught, (2) how much time you spent on each lesson, and (3) whether you made changes to the instructional activities included in each lesson.

Lesson 1: Basic Facts about HIV

Did you teach this lesson: ☐ YES ☐ NO

Approximate time spent: ☐ Less than ½ hour
☐ ½ - 1 hour
☐ More than 1 hour

How did your instruction differ from the lesson plan provided in the teacher's manual?

____
____
____
____

Lesson 2: Avoiding HIV Infection

Did you teach this lesson: ☐ YES ☐ NO

Approximate time spent: ☐ Less than ½ hour
☐ ½ - 1 hour
☐ More than 1 hour

How did your instruction differ from the lesson plan provided in the teacher's manual?

____
____
____
____

Go to the next page ⇒

Lesson 3: Choosing Abstinence

Did you teach this lesson: ☐ YES ☐ NO

Approximate time spent:
☐ Less than ½ hour
☐ ½ - 1 hour
☐ More than 1 hour

How did your instruction differ from the lesson plan provided in the teacher's manual?

____

____

____

____

Lesson 4: Communication Skills

Did you teach this lesson: ☐ YES ☐ NO

Approximate time spent:
☐ Less than ½ hour
☐ ½ - 1 hour
☐ More than 1 hour

How did your instruction differ from the lesson plan provided in the teacher's manual?

____

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____

Go to the next page ⇒

Lesson 5: Refusal Skills

Did you teach this lesson: ☐ YES ☐ NO

Approximate time spent: ☐ Less than ½ hour
☐ ½ - 1 hour
☐ More than 1 hour

How did your instruction differ from the lesson plan provided in the teacher's manual?

____
____
____
____

Lesson 6: Attitudes toward People with AIDS

Did you teach this lesson: ☐ YES ☐ NO

Approximate time spent: ☐ Less than ½ hour
☐ ½ - 1 hour
☐ More than 1 hour

How did your instruction differ from the lesson plan provided in the teacher's manual?

____
____
____
____

Go to the next page ⇒

Overall, how difficult was it to use this curriculum?

- ☐ Extremely difficult
- ☐ Somewhat difficult
- ☐ Slightly difficult
- ☐ Not at all difficult

How could the curriculum be made easier to use?

HANDBOOK OVERVIEW

This booklet is part of a series of eight booklets included in the *Handbook for Evaluating HIV Education*. The handbook contains evaluation designs and measurement tools necessary to collect data on the basic program components of policy development, curriculum design, teacher training, and student outcomes. The eight booklets are listed below.

1. Evaluating HIV Education Programs
2. Developing and Revising HIV Policies
3. Appraising an HIV Curriculum
4. Evaluating HIV Staff Development Programs
5. Assessment Instruments for Measuring Student Outcomes: Grades 5-7
6. Assessment Instruments for Measuring Student Outcomes: Grades 7-12
7. Choosing and Using an External Evaluator
8. Reporting Results of HIV Education Evaluations

For further information on the use of these booklets, please contact your state HIV coordinator or your CDC project officer.

Evaluating HIV Staff Development Programs

BOOKLET 4

DIVISION OF ADOLESCENT AND SCHOOL HEALTH
NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION
AND HEALTH PROMOTION
CENTERS FOR DISEASE CONTROL

EVALUATING HIV STAFF DEVELOPMENT PROGRAMS

W. James Popham
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TABLE OF CONTENTS

Page

INTRODUCTION 1

GUIDELINES

Guideline 1: The objectives and content of an HIV staff development program should be determined after identifying the needs of participants. 1

Guideline 2: A preliminary appraisal of an HIV staff development program's probable success can be determined by the program's internal characteristics. 3
- Instructional psychology 3
- Congruence with student curriculum 4
- Attitudes toward people with HIV or AIDS 4
- Instructional confidence 5
- Comfort with sensitive topics 5
- Knowledge of HIV and AIDS 6
- Adequate duration 6
- Final thoughts about Guideline 2 6

Guideline 3: An HIV staff development program appraisal should establish the degree to which the program was delivered as planned. 7

Guideline 4: An HIV staff development program should be chiefly evaluated by its impact on educators. 8

CONCLUSION 9

SAMPLE ASSESSMENT INSTRUMENTS 11

Sample Needs Analysis Survey to Determine the Instructional Emphases of an HIV Staff Development Program 13

Attitudes toward People with HIV or AIDS 19

Instructional Confidence 23

Comfort with Sensitive Topics 27

Knowledge of HIV and AIDS 31

Judging an HIV Staff Development Program by Its Internal Characteristics 41

Sample Participant Satisfaction Evaluation Forms 47

Sample Follow-Up Survey to Evaluate an HIV Staff Development Program 53

Introduction

Staff development programs for teachers and administrators are an important component of any educational enterprise. The more effectively educators carry out an instructional program, the more likely students will display progress in such areas as knowledge, skills, and attitudes. Well-prepared teachers will, in general, carry out an instructional program more effectively than those who are not well prepared.

Staff development for HIV education is particularly important because teachers need special skills not only to deal with the sensitive issues of sexual and drug-use behaviors that can lead to HIV infection, but also to promote students' acquisition of the interpersonal skills needed to reduce the risk of HIV infection. The following four guidelines for HIV staff development programs are intended to assist individuals responsible for designing or evaluating such programs. A staff development program in HIV education will likely take the form of an in-service workshop, course, or continuing education program for educators providing HIV education to students. It is hoped that architects of HIV staff development programs will find these guidelines useful for judging the programs they design or implement.

The guidelines deal with important choice points for evaluators of HIV staff development programs. Those wishing to consider these issues in greater detail should consult *Evaluating HIV Education Programs*, a separate booklet included in this handbook.

Sample assessment instruments are presented, beginning on page 11 of this booklet. These instruments represent the kinds of measuring devices that might be employed when evaluating the content or process of an HIV staff development program. Any of these instruments that are judged suitable for use in an actual evaluation of an HIV staff development program may require modification to be consistent with the content and objectives of that particular program.

Guideline 1: The objectives and content of an HIV staff development program should be determined after identifying the needs of participants.

The content of an HIV staff development program should flow from its objectives. A program designed to promote teachers' skills in discussing sensitive sex-related topics should obviously be different from a program designed to increase teachers' knowledge about HIV transmission routes. The determination of these objectives and content, therefore, is a particularly important undertaking.

This first guideline recommends that the objectives and resulting content of an HIV staff development program be determined after identifying the needs of those educators to whom the program will be offered. Whether the staff development program is designed for teachers who have previously received no special HIV-related instruction or for teachers who have already completed one or more such instructional programs, it is important to isolate instructional objectives that address the particular needs of those educators.

Analyze participants' needs.

The identification of participants' needs can be carried out at varying levels of cost and effort. One of the more straightforward procedures is to administer a brief survey to prospective participants in advance of the program so that they can register their reactions to the content and/or objectives under consideration. The instructional staff can then modify the content and objectives accordingly. A sample needs analysis survey is provided on page 13 of this booklet.

Another relatively simple approach is to interview, usually by phone, a sample of potential participants before the session in order to identify the kinds of objectives and content that they would like to see addressed.

It is also possible to administer pretests to ascertain participants' levels of knowledge, skill, confidence, and so on. Because such pretests are usually given when participants arrive at the program site, the instructional staff must quickly score the pretests so that results can, if appropriate, be used to modify the instructional plans. The function of formal pretests is to get a reasonably accurate fix on participants' entry behaviors—that is, on the knowledge, skills, and attitudes that participants bring to the program.

This first guideline is intended to encourage designers of HIV staff development programs to determine the program's objectives and content only after scrutiny of what participants truly need. When staff development programs fail to take into account the educators for whom they were designed, their results are typically off target, and hence reflect inappropriate instruction. Those operating HIV staff development programs should systematically determine the needs of the teachers and/or administrators to whom the programs are to be offered.

The level of effort directed to identifying participants' needs should be consistent with the particulars of the program involved. If the program is to be brief—for example, a one-hour meeting—then little attention should be given to the identification of needs. However, if the staff development program is to be a districtwide series of workshops during the entire school year, then far greater attention to the isolation of participants' needs is warranted.

Educational evaluators can play an appropriate and helpful role by gathering data regarding participants' instructional needs, then interpreting such data for those who will be providing the HIV staff development program.

Guideline 2: A preliminary appraisal of an HIV staff development program's probable success can be determined by the program's internal characteristics.

Judge the program's characteristics to determine its probable effectiveness.

Ultimately, an HIV staff development program should be appraised on the basis of its impact on the teachers and administrators who take part. That type of evaluation, obviously, can only be conducted after a program has been implemented and is, therefore, of little value to program designers. Some sort of preliminary evaluation must be used instead. The following seven effective program elements constitute evaluative criteria that program designers can use to make preliminary judgments about a program's probable effectiveness: (1) instructional psychology, (2) congruence with student curriculum, (3) attitudes toward people with HIV/AIDS, (4) instructional confidence, (5) comfort with sensitive topics, (6) knowledge of HIV and AIDS, and (7) adequate duration. If all seven of these elements are included in an HIV staff development program, that program is far more likely to be successful than if only a few are included.

Instructional psychology: The program adheres to sound principles of instructional psychology.

An HIV staff development program, like any other instructional endeavor, should be founded on established experience-based and research-based tenets of instructional practice. Designers of the program must be sufficiently conversant with the most important principles of instructional psychology to discern whether their program is consonant with such principles.

Features of effective instructional practice, such as (1) task analysis, (2) motivation, (3) modeling, (4) guided practice, (5) independent practice, and (6) review, should be a part of all HIV staff development programs. If a program has only a few of these features, it should be reviewed carefully to determine whether it needs to be broadened to include more.

The needs of adult learners must be taken into account when drawing on instructional principles such as those identified above. Motivational techniques that are effective with younger learners, for example, may need to be modified to be suitable for the teachers and administrators who are the typical participants in HIV staff development programs.

Congruence with student curriculum: The program is aligned with the HIV instructional program for students.

Staff development programs are typically provided so that educators can deliver a specific instructional program more effectively. HIV education, whether offered as part of a comprehensive health program or as a separate curricular entity, focuses on distinctive knowledge, skills, and attitudes. Thus, the HIV staff development program should be closely related to the specific HIV education program that will be offered to students. Although some content in an HIV staff development program will be useful to teachers in instructional contexts other than HIV education, an HIV staff development program should not be a general, one-size-fits-all endeavor. On the contrary, teachers and administrators need to become thoroughly conversant with the particulars of the HIV education that they will be providing to students. Those providing the HIV staff development program must thus make certain that it is congruent with the local HIV education program for students.

Attitudes toward people with HIV or AIDS: The program addresses teachers' attitudes and beliefs regarding people infected with HIV and people who have AIDS.

Most people know that HIV is not transmitted through casual contact. However, many of these same people may still avoid any contact with people who are infected with HIV or who have AIDS. It is not enough for educators merely to know the facts about HIV and AIDS. They must also possess appropriate attitudes toward people who are infected with HIV or who have AIDS. To deliver a message of safety to their students, teachers must themselves believe that it is not dangerous to be around someone infected with HIV or someone who has AIDS. Compelling evidence must be presented so that participants can see how HIV is and is not transmitted. A sample instrument that assesses teachers' attitudes toward people with HIV or AIDS is provided on page 19 of this booklet.

Instructional confidence: The program promotes teachers' confidence in their ability to deliver HIV education for students.

There is ample evidence that people's confidence in their ability to perform a given skill is an important factor in their performance of that skill. Teachers will perform more successfully when they are confident that they can skillfully deliver the instruction called for in the HIV education program. Those preparing to teach HIV education will frequently find themselves confronting unfamiliar topics and skills. They need to have opportunities to develop confidence in their ability to address these new topics and skills. It is insufficient merely to present new HIV-related content to educators. To gain a genuinely high level of confidence, educators must be allowed ample practice opportunities to master the content. A sample instrument to help determine teachers' instructional confidence is provided on page 23 of this booklet.

Comfort with sensitive topics: The program increases teachers' comfort in discussing sensitive topics.

HIV education presents educators with a special challenge because of the sensitive topics that it must cover. Because HIV transmission involves sexual behaviors and intravenous drug use, well-prepared educators must be comfortable discussing these topics with their students. They have to be familiar with slang terms so that they can recognize them when students use them. Teachers also need to know the technical names for sexual organs and body functions to use during class discussions. To increase educators' comfort in discussing these sensitive and sometimes controversial topics, teachers and administrators should be made familiar with state and district policies regarding the teaching of such topics. A sample instrument that assesses teachers' comfort with sensitive topics is provided on page 27 of this booklet.

Knowledge of HIV and AIDS: The program includes up-to-date information and resources related to AIDS and HIV transmission.

Scientific information about HIV and AIDS is steadily increasing. It is important, therefore, that HIV educators learn not only the current facts about HIV and AIDS but also where and how to keep those facts up to date. Designers of an HIV staff development program should have the factual basis of their program reviewed by a physician or health educator who is conversant with the most recent developments regarding HIV and AIDS. A sample assessment instrument to help determine teachers' knowledge of HIV and AIDS is provided on page 31 of this booklet.

Adequate duration: The program is of sufficient instructional duration.

An effective HIV staff development program needs to do more than provide lesson plans for teachers. Although no empirical evidence has indicated the minimal amount of time necessary for an effective staff development program, a program must certainly last more than a few hours to cover such topics as teaching interpersonal skills, promoting appropriate attitudes toward people with HIV and AIDS, fostering confidence in educators' ability to deliver the program, achieving comfort in discussing sensitive topics, and attaining information about HIV and AIDS. An HIV staff development program of only an hour or two will surely yield only modest benefits.

Designers of HIV staff development programs will need to employ their best professional judgment about program length in light of how much instructional time is realistically available for staff development. If the program deals only with HIV-related knowledge, then a few hours might do the job satisfactorily. However, if the program is designed to promote teachers' abilities to help their students master interpersonal skills, then several days may be required. In general, it is wiser to err in the direction of too long rather than too short. It takes time to prepare educators to teach HIV education effectively.

Final thoughts about Guideline 2

Guideline 2 suggests that the probable success of an HIV staff development program can be estimated on the basis of the extent to which it incorporates the previously described program elements. The use of such internal elements to appraise a program should not replace the need for a postprogram evaluation of the program's effects. Guideline 2 can, however, help increase the probability that an HIV staff development program will be successful. A sample rating form is provided on page 41 to assist evaluators in their review of a staff development program's internal characteristics.

Guideline 3: HIV staff development program appraisal should establish the degree to which the program was delivered as planned.

This guideline focuses on actually carrying out an HIV staff development program. Was the program implemented as it was supposed to be? Was the planned content covered? Were the instructional activities carried out as anticipated? In short, was the program that was actually offered to educators the program that was planned?

Determine how the program was delivered.

To ascertain whether an HIV staff development program was properly implemented is usually not difficult. An evaluator merely needs to describe what transpired during the program and determine whether that description matches what was intended.

One straightforward way to determine if the actual program matches the intended program is to observe instructional activity during the program. The more systematic this observation can be, the more confidence one can place in the observational data. A second approach is to have the instructors of the program, or even the participants in the program, respond to questions about what they experienced during the HIV staff development program.

This guideline is offered chiefly to remind evaluators not to overlook implementation evaluation. Some evaluators do not document the extent to which what was instructionally intended by the program actually took place. Without such documentation, it is difficult to determine whether a program's lack of success is a function of faulty design or faulty delivery. Even with successful programs, evaluators need to know whether to credit positive results to the program as planned or the program as delivered.

Guideline 4: An HIV staff development program should be chiefly evaluated by its impact on educators.

Evaluations of staff development programs have one of two purposes. The first purpose of evaluation is to uncover data that will help improve a program under development. The second purpose is to gather information that will reveal the success or failure of a more fully developed program and influence a decision to continue or terminate the program.

In both cases, evaluators of an HIV staff development program must decide what sorts of evaluative data to gather. The judgment of participants about the program's quality is one source of useful data. Participants can be asked to register their reactions to the program's (1) content, (2) instructional procedures, and (3) logistical arrangements. All three sorts of reactions can prove useful.

Judge an HIV staff development program by its effects.

The evaluator must make sure that the data-gathering forms and the way they are used are as conducive as possible to gathering accurate and decision-relevant data. If the instrument is designed to enhance anonymity, for example, the resultant data concerning participant satisfaction will allow more valid inferences than data provided by participants who believe that their responses can be traced to them. Sample participant satisfaction evaluation forms begin on page 47 of this booklet.

Although data on participant satisfaction can prove highly illuminating to decision makers, evaluators have other meaningful criteria—namely, the changes that did (or did not) take place in participants as a consequence of the program. Such changes might include increased knowledge, modified attitudes, acquisition of skills, or changes in teachers' subsequent classroom behaviors. Typically, a simple pretest-posttest data-gathering design is employed to discern whether the staff development program is yielding changes in participants. For example, an evaluator could measure participants' knowledge regarding HIV before and after the program and identify the degree to which participants' knowledge has increased.

An evaluator must carefully decide what types of participant-change data to gather. There are both advantages and disadvantages in choosing to focus assessment procedures on variables such as knowledge, skills, attitudes, or behavior. Several factors, such as the availability of suitable assessment instruments, will affect these choices. The actual content of the HIV staff development program should also have an influence on the selection of pretest-posttest assessment devices. If the program is intended only to promote participants' knowledge, it would be inappropriate to assess their attitudes and behaviors.

The set of sample assessment devices beginning on page 11 might be used or adapted for the evaluation to improve an ongoing HIV staff development program. Any assessment instruments that are used should be consistent with the instructional emphases of the staff development program.

An HIV staff development program that has been in place for some time (and has already been improved) should be subjected to a rigorous evaluation so that its impact can be determined. The evaluator of an established HIV staff development program should try to determine what participants think about the program. Further, the evaluator should examine whether the program brings about meaningful changes in the knowledge, attitudes, skills, and/or behaviors of these participating educators. Of particular interest is whether the teachers who received the HIV staff development program are actually putting into practice what they learned. Securing such information will usually entail some sort of follow-up questionnaire by mail or by telephone. A sample follow-up questionnaire can be found on page 53 of this booklet.

The purpose of gathering data from participants is to evaluate the program rather than the participants. Accordingly, participants should complete all assessment instruments anonymously.

Previously described on page 8 of the booklet *Evaluating HIV Education Programs*, the *HIV Education Survey* distributed by CDC/Division of Adolescent and School Health or Westat may also be useful in designing local HIV staff development workshops. Several questions in this survey deal with the nature and duration of HIV staff development programs. One question, for example, asks, "How many of your staff members have received preservice or in-service training to teach HIV education?" This information may be quite helpful in determining local needs and formulating optimal training programs.

Conclusion

This booklet provides those who design and/or appraise HIV staff development programs with a set of guidelines to use in determining the quality of such programs. Guideline 1 deals with the necessity for identifying participants' needs before the program begins in order to determine the program's objectives and content.

Guideline 2 features seven elements of successful HIV staff development programs. Guideline 3 stresses the importance of implementation evaluation. Guideline 4 deals with the need to evaluate staff development programs according to the program's effects.

In the following pages, several assessment devices are presented that may be used—as is or with modifications—in the evaluation of HIV staff development programs.

Sample Assessment Instruments

The following pages contain eight sample assessment instruments: (1) *Sample Needs Analysis Survey to Determine the Instructional Emphases of an HIV Staff Development Program,* (2) *Attitudes Toward People with HIV or AIDS,* (3) *Instructional Confidence,* *(4) Comfort with Sensitive Topics, (5) Knowledge of HIV and AIDS, (6) Judging an HIV Staff Development Program by Its Internal Characteristics, (7) Sample Participant Satisfaction Evaluation Forms,* and (8) *Sample Follow-Up Survey to Evaluate an HIV Staff Development Program.* Those who are carrying out the evaluation of an HIV staff development program may find one or more of them useful.

These instruments should not be considered prescriptive. In the evaluation of a given HIV staff development program, it is likely that several of these instruments would not match the program's instructional emphases. Evaluators are free to select any of the instruments presented here and modify them as needed.

Each instrument is preceded by a description of the instrument, a rationale for its use, and a suggested scoring scheme.

Sample Needs Analysis Survey to Determine the Instructional Emphases of an HIV Staff Development Program

Assessment Focus: Participants' current status regarding HIV-relevant skills, knowledge, and attitudes that might be emphasized in an HIV staff development program.

General Description

This sample survey is intended to secure information about content that might be incorporated into an HIV staff development program. It can be administered in its current form by mail or, with a few minor alterations, by telephone. The advantage of using a telephone interview is that you can ask the respondent to elaborate or clarify an answer. The disadvantage of the telephone approach, however, is that it eliminates respondents' anonymity.

Rationale

If not properly selected, the instructional emphases of an HIV staff development program may fail to coincide with the genuine needs of participants. The use of a needs analysis survey such as this could provide the planners of an HIV staff development program with the data needed to particularize the program effectively.

Scoring Procedures

Responses can simply be totalled for each response option: the form can be altered by adding or deleting potential topic areas.

NEEDS ANALYSIS FOR THE UPCOMING HIV STAFF DEVELOPMENT PROGRAM

In six weeks, you will be taking part in a district-sponsored HIV staff development program for all of the district's certificated personnel. Please complete this survey **anonymously**, then return it by District Mail to "Health Education Coordinator, Administrative Complex, Room 205." Results of the needs analysis survey will be used to tailor the staff development program to the needs of our district's teachers and administrators.

For each topic listed below, please indicate how confident you are about your knowledge or skills and whether you think the topic should be included in the HIV staff development program.

Please respond honestly. Do not put your name on the survey.

	Potential Topic	Your Current Confidence?			Should Be Included?	
1.	Basic facts about HIV and AIDS	HI	AVG	LO	YES	NO
2.	How to get accurate, up-to-date information about HIV and AIDS	HI	AVG	LO	YES	NO
3.	Changing students' HIV-related attitudes and behaviors	HI	AVG	LO	YES	NO
4.	How to promote students' accurate perceptions of their vulnerability to HIV infection	HI	AVG	LO	YES	NO
5.	How to discuss sensitive topics with students	HI	AVG	LO	YES	NO
6.	How to teach students the skills to help them refrain from engaging in sexual intercourse	HI	AVG	LO	YES	NO
7.	How to develop students' HIV-related interpersonal skills (e.g., self-esteem)	HI	AVG	LO	YES	NO
8.	How to teach about condom use	HI	AVG	LO	YES	NO
9.	How to teach students to refrain from injecting drugs	HI	AVG	LO	YES	NO
10.	Where and when to get tested for HIV infection	HI	AVG	LO	YES	NO
11.	How to involve peers and parents in HIV education programs	HI	AVG	LO	YES	NO

Potential Topic	Your Current Confidence?			Should Be Included?	
12. How to deal with students or staff who are infected with HIV	HI	AVG	LO	YES	NO
13. How to deal with community controversy surrounding HIV education	HI	AVG	LO	YES	NO
14. Other topics?					
____________________	HI	AVG	LO	YES	NO
____________________	HI	AVG	LO	YES	NO
____________________	HI	AVG	LO	YES	NO

Thank you for completing this survey.

Attitudes toward People with HIV or AIDS

Assessment Focus: Educator attitudes toward people with AIDS or infected with HIV

General Description

This 10-item instrument measures educators' acceptance of and attitudes toward students or colleagues who have AIDS or are infected with HIV. Educators are asked to respond to each statement on a 5-point scale.

Rationale

Attitudes toward others have long been recognized as a predisposing factor of behavior. In the United States, people who have AIDS or are infected with HIV have often been stigmatized by mainstream society. Intolerant attitudes toward these people often lead to intolerant behaviors against them. Changing such attitudes is thus a key objective in an HIV staff development program.

Scoring Procedures

To obtain a total score for each educator, add the point values of responses. Total scores can range from 50 points (indicating high acceptance of persons with HIV or AIDS) to 10 points (indicating low acceptance of persons with HIV or AIDS).

The following scale should be used to score items.

For items 1, 2, 4, 8, and 10:

Strongly Agree	5 points
Agree	4 points
Not Sure	3 points
Disagree	2 points
Strongly Disagree	1 point

For items 3, 5, 6, 7, and 9:

Strongly Agree	1 point
Agree	2 points
Not Sure	3 points
Disagree	4 points
Strongly Disagree	5 points

ATTITUDES TOWARD PEOPLE WITH HIV OR AIDS

Directions: Please respond anonymously. Read each item and check the response that fits best for you.

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
1. I wouldn't mind having a student with AIDS in my classroom.	( )	( )	( )	( )	( )
2. A student who is infected with HIV should be allowed to eat lunch in the school cafeteria.	( )	( )	( )	( )	( )
3. I would avoid a student whose family member had AIDS.	( )	( )	( )	( )	( )
4. I wouldn't mind attending a faculty meeting with someone who was infected with HIV.	( )	( )	( )	( )	( )
5. Students who have AIDS should be segregated from other students.	( )	( )	( )	( )	( )
6. Students who have AIDS should not play sports with other students.	( )	( )	( )	( )	( )
7. I would feel uncomfortable about individually tutoring a student infected with HIV.	( )	( )	( )	( )	( )
8. People who have AIDS should be allowed to work in restaurants and cafeterias.	( )	( )	( )	( )	( )
9. If I thought a teacher was infected with HIV, I would be afraid to shake hands with that teacher.	( )	( )	( )	( )	( )
10. I would feel comfortable hugging a friend who has AIDS.	( )	( )	( )	( )	( )

Instructional Confidence

Assessment Focus: Educator confidence in the ability to provide HIV education

General Description

This 10-item instrument assesses educators' confidence in their ability to carry out a variety of activities necessary to provide HIV education.

Rationale

Success in providing effective HIV education requires more than knowledge about HIV. It also requires educators to be confident in their ability to provide students with an effective instructional program.

Scoring Procedures

To obtain a total score for each educator, add the point values of responses. Total scores can range from 50 points (indicating a high degree of confidence) to 10 points (indicating a low degree of confidence). The following scale should be used to score items.

Completely Confident	5 points
Very Confident	4 points
Somewhat Confident	3 points
Not Very Confident	2 points
Not at All Confident	1 point

INSTRUCTIONAL CONFIDENCE

Directions: Please respond anonymously. Read each item and check the response that fits best for you.

How confident are you that you can:	Completely Confident	Very Confident	Somewhat Confident	Not Very Confident	Not at All Confident
1. Obtain up-to-date information about HIV?	( )	( )	( )	( )	( )
2. Present accurate information about HIV infection and AIDS to students?	( )	( )	( )	( )	( )
3. Answer parents' questions about HIV education?	( )	( )	( )	( )	( )
4. Discuss high-risk sexual behaviors with students?	( )	( )	( )	( )	( )
5. Help students develop skills they will need to refrain from engaging in intercourse?	( )	( )	( )	( )	( )
6. Explain to students at appropriate ages how a condom should be used?	( )	( )	( )	( )	( )
7. Discuss high-risk drug behaviors with students?	( )	( )	( )	( )	( )
8. Help students to refrain from injecting drugs?	( )	( )	( )	( )	( )
9. Increase students' tolerance toward people with AIDS?	( )	( )	( )	( )	( )
10. Help students reach more accurate perceptions of their own vulnerability to HIV infection?	( )	( )	( )	( )	( )

Comfort with Sensitive Topics

Assessment Focus: Educator comfort in the discussion of sensitive topics related to HIV education

General Description

This 10-item instrument assesses educators' comfort in discussing HIV-related topics that might be addressed during an HIV education program. Educators indicate their comfort in discussing these topics by responding on a 5-point "comfort" scale.

Rationale

Success in delivering an HIV curriculum depends on more than knowledge of HIV and the behaviors that put one at risk of infection. Because sensitive topics related to sexual behaviors and intravenous drug use will be part of an HIV curriculum, it is important that educators be comfortable discussing these topics.

Scoring Procedures

To obtain a total score for each educator, add the point values of responses. Total scores can range from 50 points (indicating a high degree of comfort) to 10 points (indicating a low degree of comfort). The following scale should be used to score items.

Completely Comfortable	5 points
Very Comfortable	4 points
Somewhat Comfortable	3 points
Not Very Comfortable	2 points
Not at All Comfortable	1 point

Although a total score can be computed, the specific nature of the instrument's 10 items should incline evaluators to engage in item-by-item scoring. Certain topics are far more likely than others to induce embarrassment on the part of educators. For example, most educators would be more comfortable discussing "how HIV is transmitted" than "male genitalia." Staff development programs can be focused on alleviating educators' discomfort regarding particular topics with which those educators are least comfortable.

COMFORT WITH SENSITIVE TOPICS

Directions: Please respond anonymously. Read each item and check the response that fits best for you.

How comfortable are you in discussing the following topics with students?*	Completely Comfortable	Very Comfortable	Somewhat Comfortable	Not Very Comfortable	Not at All Comfortable
1. How HIV is transmitted	( )	( )	( )	( )	( )
2. Injected drug use	( )	( )	( )	( )	( )
3. Sexual intercourse	( )	( )	( )	( )	( )
4. AIDS	( )	( )	( )	( )	( )
5. Alcohol use	( )	( )	( )	( )	( )
6. Condom use	( )	( )	( )	( )	( )
7. Sexual abstinence	( )	( )	( )	( )	( )
8. Male genitalia	( )	( )	( )	( )	( )
9. Female genitalia	( )	( )	( )	( )	( )
10. Nonsexual ways of displaying affection	( )	( )	( )	( )	( )

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*Assume, for purposes of completing this inventory, that your district's policies permit the discussion of all topics listed.

Knowledge of HIV and AIDS

Assessment Focus: Educator HIV and AIDS knowledge related to HIV-risk behaviors

General Description

This 25-item instrument measures functional knowledge about HIV and AIDS. The instrument may be used to: (1) measure the accuracy of educators' knowledge about HIV and AIDS, and (2) measure the degree of educators' confidence in their knowledge about HIV and AIDS. For each of 25 statements, educators are to choose one of the following responses: I am sure it's true; I think it's true; I don't know; I think it's false; I am sure it's false.

Rationale

Functional knowledge is information that relates directly to one's engagement in HIV-risk behaviors, as opposed to information indirectly related to one's HIV-risk behaviors. Functional knowledge about HIV and AIDS is necessary to eliminate or reduce the risk of HIV transmission and to eliminate incorrect notions about HIV transmission. Questions regarding more general informational items about HIV and AIDS, therefore, were not included in this instrument.

Scoring Procedures

This instrument can be scored either for knowledge or for confidence in one's knowledge.

Knowledge Measure

To score this instrument for knowledge, consider only whether educators indicate that an item is true or false or that they do not know whether it is true or false. Each correct answer receives one point, and each incorrect or "don't know" response receives no points. For example, a false statement would be scored as correct (and the respondent given one point) if the respondent answered either "I think it's false," or "I am sure it's false."

Total scores can range from 0 points (no items correct) to 25 points (all items correct).

Scoring Key

True:	1, 2, 5, 6, 7, 9, 10, 11, 13, 16, 17, 21, 22, 24, 25
False:	3, 4, 8, 12, 14, 15, 18, 19, 20, 23

An item-by-item analysis of the group's responses can help identify those content areas that may require targeted instruction.

Confidence Measure

To score this instrument for confidence in correctly held knowledge about HIV and AIDS, assign a value of 1 to 5 points for each item. The highest number of points possible is assigned to an item that an individual answers correctly with a high degree of confidence ("I am sure it's true," or "I am sure it's false"). An answer marked correctly with a lower degree of confidence ("I think it's true," or "I think it's false"), marked "I don't know," or marked incorrectly receives a lower number of points.

If a statement is true, points are assigned to responses as follows:

Scoring for True Items

5 points – I am sure it's true.
4 points – I think it's true.
3 points – I don't know.
2 points – I think it's false.
1 point – I am sure it's false.

If a statement is false, points are assigned to responses as follows:

Scoring for False Items

5 points – I am sure it's false.
4 points – I think it's false.
3 points – I don't know.
2 points – I think it's true.
1 point – I am sure it's true.

"I don't know" responses receive more points than incorrect answers because confidence in incorrect knowledge is potentially more damaging than uncertainty regarding the knowledge. (Persons with some degree of confidence in an incorrect answer are more likely to relay this erroneous information to others than are persons who know they do not know the correct answer.)

Total scores for confidence in correctly held knowledge can range from 25 points (all answers incorrect with a high degree of confidence) to 125 points (all answers correct with a high degree of confidence). A comparison of the group's mean total score can be used to determine changes in confidence in correctly held knowledge from pretest to posttest. In addition, an item-by-item analysis of the group's responses can help identify those content areas that may require targeted instruction.

If the instrument is scored with an emphasis on correctly held knowledge, it is important to clearly indicate this fact in reports that are produced. Otherwise, reported results may be misinterpreted. When presenting results, use phrasing similar to the following:

> Besides being scored for AIDS and HIV knowledge, the instrument was also scored to determine respondents' confidence in correctly held knowledge. Items answered correctly with a high degree of confidence received the highest number of points (5), and items answered incorrectly with a high degree of confidence received the lowest number of points (1).

KNOWLEDGE OF HIV AND AIDS

Directions: Please respond anonymously. Read each item and check the response that fits best for you.

	I am sure it's true.	I think it's true.	I don't know.	I think it's false.	I am sure it's false.
1. Many people who are infected with HIV can look and feel healthy.	( )	( )	( )	( )	( )
2. Drug users can reduce their chances of becoming infected with HIV by not sharing needles.	( )	( )	( )	( )	( )
3. AIDS can be cured if it is treated early enough.	( )	( )	( )	( )	( )
4. Only a person who is sick with AIDS can give HIV to others.	( )	( )	( )	( )	( )
5. A person can become infected with HIV by having unprotected (no condom) sexual intercourse with someone who is infected with HIV.	( )	( )	( )	( )	( )
6. Mothers can pass HIV to their babies through breast milk.	( )	( )	( )	( )	( )
7. Males who are infected with HIV can give it to another person through their semen.	( )	( )	( )	( )	( )
8. People who have AIDS always show clear signs of being sick.	( )	( )	( )	( )	( )
9. People who are infected with HIV can give it to another person through their blood.	( )	( )	( )	( )	( )
10. A mother can pass HIV to her unborn child.	( )	( )	( )	( )	( )

	I am sure it's true.	I think it's true.	I don't know.	I think it's false.	I am sure it's false.
11. A person can become infected with HIV by sharing needles that have been used to inject steroids.	( )	( )	( )	( )	( )
12. A person can become infected with HIV by smoking the same cigarette that someone with HIV has smoked.	( )	( )	( )	( )	( )
13. People can reduce their chances of becoming infected with HIV by using a latex condom during sexual intercourse.	( )	( )	( )	( )	( )
14. A person can become infected with HIV by being bitten by an insect, such as a mosquito or flea.	( )	( )	( )	( )	( )
15. A person can become infected with HIV by donating (giving) blood.	( )	( )	( )	( )	( )
16. There is a period of time when a person infected with HIV can test negative on an HIV-antibody test.	( )	( )	( )	( )	( )
17. A person who has had a positive HIV-antibody test result can give HIV to someone else.	( )	( )	( )	( )	( )
18. A person can become infected with HIV by using public bathrooms.	( )	( )	( )	( )	( )
19. People who are careful to have sexual intercourse only with healthy-looking partners won't become infected with HIV.	( )	( )	( )	( )	( )
20. People who are infected with HIV can give it to other people by shaking hands.	( )	( )	( )	( )	( )

	I am sure it's true.	I think it's true.	I don't know.	I think it's false.	I am sure it's false.
21. Drug users can reduce their chances of becoming infected with HIV by cleaning needles with bleach before injecting drugs.	( )	( )	( )	( )	( )
22. People can be infected with HIV and not know they have it.	( )	( )	( )	( )	( )
23. When used during sexual intercourse, condoms are 100% effective in protecting people from becoming infected with HIV.	( )	( )	( )	( )	( )
24. People can get their blood tested to see if they have been infected with HIV.	( )	( )	( )	( )	( )
25. Not using a condom during sexual intercourse with a person who has injected (shot up) drugs increases a person's chances of becoming infected with HIV.	( )	( )	( )	( )	( )

Judging an HIV Staff Development Program by Its Internal Characteristics

Assessment Focus: Program designers' rating of internal characteristics of an HIV staff development program

General Description

This rating form provides an opportunity for program designers to rate the strengths of their HIV staff development program prior to program implementation. Preliminary judgments about a program's probable effectiveness center around the following seven internal characteristics: (1) instructional psychology, (2) congruence with student curriculum, (3) attitudes toward people with HIV or AIDS, (4) instructional confidence, (5) comfort with sensitive topics, (6) knowledge of HIV and AIDS, and (7) adequate duration.

Rationale

If all seven of the internal characteristics are included in an HIV staff development program, that program is far more likely to be successful than if only a few are included. The use of a rating form to assess the extent to which the seven characteristics have been included could provide the planners with the data needed to make improvements to the program before it is implemented.

Scoring Procedures

The seven internal characteristics are rated on a 5-point scale. For example, the scale for assessing the internal characteristic of knowledge of HIV and AIDS ranges from "All HIV and AIDS information up to date; resources for additional information provided" to "some HIV and AIDS information dated and inaccurate; no additional resources provided."

Program designers may wish to fill out this form individually or compile answers from all program committee members for a group response.

Internal Characteristics Rating Form

HIV staff development program under consideration: ______________________________

____

1. Instructional Psychology

Clearly adheres to sound instructional practices	Embodies few principles drawn from instructional psychology

2. Congruence with Student Curriculum

Completely consistent with the HIV instructional program for students	Relatively unrelated to the instructional program for students

3. Attitudes toward People with HIV or AIDS

Substantial effort given to promoting positive attitudes toward persons with HIV or AIDS	Little attention given to promoting positive attitudes toward persons with HIV or AIDS

4. Instructional Confidence

Much attention given to enhancing participants' confidence in teaching about HIV	Little attention given to increasing participants' confidence in teaching about HIV

5. Comfort with Sensitive Topics

Substantial effort focused on increasing participants' ease in discussing sensitive topics	No instruction on increasing participants' ease in discussing sensitive topics

6. Knowledge of HIV and AIDS

All HIV and AIDS information up to date; resources for additional information provided	Some HIV and AIDS information dated and inaccurate; no additional resources provided

7. Adequate Duration

3-5 days devoted to the HIV staff development program	Only a few hours devoted to the HIV staff development program

Sample Participant Satisfaction Evaluation Forms

Assessment Focus: Participants' evaluation of an HIV staff development program

General Description

These two single-sheet forms provide an opportunity for the participants in a staff development program to evaluate the program at its conclusion.

Rationale

Two separate forms, to be distributed on separate sheets, are provided so that participants can complete the Evaluation Checklist candidly with complete confidence that their responses cannot be identified by their handwriting. The separate Written Comment Evaluation Survey offers participants an opportunity to elaborate through written comments if they wish to do so.

Scoring Procedures

Because such evaluation forms must be designed to match the particular HIV staff development program, the following two forms are provided as examples only. Scoring, therefore, would be based on the particulars of the form being used.

PARTICIPANT SATISFACTION EVALUATION CHECKLIST

Directions: Please evaluate this staff development workshop so that future workshops can be made more effective. *Do not* put your name on this form. Your answers will be anonymous. When you are finished, please deposit the two sheets in the box marked "Evaluation Forms" as you leave the room.

1. Please rate the following workshop topics on (1) the quality of their presentation in the workshop, and (2) their importance for your future presentations of HIV education to your students:

	QUALITY			IMPORTANCE		
	Excellent	Satisfactory	Poor	Very Important	Somewhat Important	Not at All Important
a. Knowledge about HIV and AIDS	( )	( )	( )	( )	( )	( )
b. Discussing sensitive topics	( )	( )	( )	( )	( )	( )
c. Teaching students skills to refrain from engaging in sexual intercourse	( )	( )	( )	( )	( )	( )
d. Teaching condom use	( )	( )	( )	( )	( )	( )
e. Teaching students to refrain from injecting drugs	( )	( )	( )	( )	( )	( )
f. Dealing with parental discomfort	( )	( )	( )	( )	( )	( )
g. District policies related to HIV/AIDS	( )	( )	( )	( )	( )	( )

2. Please rate the quality of the following workshop instructional activities:

	Excellent	Satisfactory	Poor
a. Lecture sessions	( )	( )	( )
b. Small group discussions	( )	( )	( )
c. Participant exercises	( )	( )	( )
d. Role-plays	( )	( )	( )

3. Please rate the quality of the following:

	Excellent	Satisfactory	Poor
a. Length of instructional segments	( )	( )	( )
b. Quality of the instructional staff	( )	( )	( )
c. Room arrangements	( )	( )	( )
d. Instructional materials	( )	( )	( )

	Excellent	Good	Satisfactory	Fair	Poor
4. What is your overall rating of the workshop?	( )	( )	( )	( )	( )

PARTICIPANT SATISFACTION
WRITTEN COMMENT EVALUATION SURVEY

What additional topics should be included in the workshop?

Was too little or too much time spent on any of the topics included in the workshop?

What did you like *most* about the workshop?

What did you like *least* about the workshop?

What other comments do you have about the workshop?

Thank you for completing this survey.

Sample Follow-Up Survey to Evaluate an HIV Staff Development Program

Assessment Focus: Participants' long-term reactions to an HIV staff development program

General Description

This two-page form obtains the reactions of participants toward an HIV staff development program after those individuals have returned to their regular instructional assignments.

Rationale

Participants in a staff development program can often appraise the worth of that program more accurately after they have attempted to use what they learned. Follow-up participant evaluations, therefore, will often yield participant insights not immediately apparent at the program's conclusion.

Scoring Procedures

The contents of a follow-up participant evaluation form should be customized to reflect a particular staff development program's instructional emphases. In addition, the length of time between the program's conclusion and the solicitation of participants' reactions will vary, depending on how long it would typically take for participants to use what they have learned in the program. Scoring, therefore, would be based on the particulars of the form being used.

FOLLOW-UP SURVEY FOR PARTICIPANTS

Six months ago, you attended a three-day HIV staff development workshop. The purpose of this survey is to determine how helpful that workshop was, now that you have had an opportunity to use what you learned. The information that you provide will be used to improve future staff development programs.

Please *do not* put your name on this form. Your answers will be anonymous. When you have completed this survey, return it in the enclosed stamped, self-addressed envelope.

1. Have you provided HIV instruction to students since you completed the staff development workshop?

   ☐ YES
   ☐ NO (If no, please stop here and return the survey in the enclosed envelope.)

2. About how many classroom periods (one hour) of HIV instruction have you provided since you completed the staff development workshop? ________

3. How important were the following workshop topics in your efforts to provide quality HIV education to your students?

		Very Important	Somewhat Important	Not at All Important
a.	Knowledge about HIV and AIDS	( )	( )	( )
b.	Ways to discuss sensitive topics	( )	( )	( )
c.	How to teach skills to help students refrain from engaging in sexual intercourse	( )	( )	( )
d.	Ways to teach condom use	( )	( )	( )
e.	How to teach students to refrain from injecting drugs	( )	( )	( )
f.	Ways to deal with parental discomfort	( )	( )	( )
g.	District policies related to HIV/AIDS	( )	( )	( )

4. Which aspect of the staff development workshop was the *most* useful to you in providing HIV instruction to your students?

   ____

   ____

   ____

5. Which aspect of the staff development workshop was the *least* useful to you in providing HIV instruction to your students?

6. What additional topics should have been included in the staff development program?

7. What topics should have been treated more extensively in the staff development workshop?

8. What other comments do you have about changes needed in the staff development workshop?

Thank you for completing this survey.

HANDBOOK OVERVIEW

This booklet is part of a series of eight booklets included in the *Handbook for Evaluating HIV Education*. The handbook contains evaluation designs and measurement tools necessary to collect data on the basic program components of policy development, curriculum design, teacher training, and student outcomes. The eight booklets are listed below.

1. Evaluating HIV Education Programs
2. Developing and Revising HIV Policies
3. Appraising an HIV Curriculum
4. Evaluating HIV Staff Development Programs
5. Assessment Instruments for Measuring Student Outcomes: Grades 5-7
6. Assessment Instruments for Measuring Student Outcomes: Grades 7-12
7. Choosing and Using an External Evaluator
8. Reporting Results of HIV Education Evaluations

For further information on the use of these booklets, please contact your state HIV coordinator or your CDC project officer.

Assessment Instruments for Measuring Student Outcomes

Grades 5-7

BOOKLET 5

DIVISION OF ADOLESCENT AND SCHOOL HEALTH
NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION
AND HEALTH PROMOTION
CENTERS FOR DISEASE CONTROL

ASSESSMENT INSTRUMENTS FOR MEASURING STUDENT OUTCOMES

GRADES 5-7

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TABLE OF CONTENTS

Page

INTRODUCTION . . . 1
  Developmental History . . . 1
  Organizational Preview . . . 2
  Securing Permission to Gather Data . . . 2
  Using the Assessment Instruments . . . 3

KNOWING ABOUT HIV AND AIDS . . . 5
  (Assessment Focus: HIV and AIDS knowledge related to HIV-risk behaviors)
    General Description . . . 5
    Rationale . . . 5
    Scoring Procedures . . . 5
    Administration Directions . . . 9
    The Instrument: Form A . . . 11
    The Instrument: Form B . . . 15

HOW WOULD YOU FEEL? . . . 19
  (Assessment Focus: Attitudes toward people with AIDS)
    General Description . . . 19
    Rationale . . . 19
    Scoring Procedures . . . 19
    Administration Directions . . . 21
    The Instrument . . . 23

YOUR ATTITUDES . . . 27
  (Assessment Focus: Three attitudinal dimensions related to HIV-risk behaviors)
    General Description . . . 27
    Rationale . . . 27
    Scoring Procedures . . . 27
    Administration Directions . . . 29
    The Instrument . . . 31

HOW SURE ARE YOU? . . . 37
  (Assessment Focus: Confidence in one's ability to resist peer pressures)
    General Description . . . 37
    Rationale . . . 37
    Scoring Procedures . . . 37
    Administration Directions . . . 39
    The Instrument . . . 41

Introduction

This booklet contains a set of assessment instruments specifically developed to assist those who wish to evaluate an HIV education program. The instruments are designed to assess knowledge, attitudes, and behaviors that frequently serve as instructional targets of HIV education. The instruments are provided to offer a range of options that evaluators may wish to consider. The instruments may be used as is or may be modified to become more consistent with a particular program's instructional emphases.

The assessment instruments in this booklet were designed for students in grades 5 through 7. A companion booklet provides instruments for students in grades 7 through 12. It should be noted that at grade 7—the division point between the two sets of assessment instruments—a choice must be made between the instrument sets. Because there are substantial variations in the maturity and achievement levels of students in different locales, if the instruments are to be used with students in grades 6, 7, or 8, both sets of instruments should be reviewed to identify those appropriate for a particular group of students.

The absence of assessment instruments for lower grades does not imply that HIV-relevant instruction should not be provided in those grades. However, because instruction in lower grades tends to deal with more general objectives such as health promotion and self-esteem, no separate set of assessment instruments was developed for those grade levels.

Developmental History

The assessment devices in this booklet were prepared as part of a project supported by the Division of Adolescent and School Health, Centers for Disease Control (CDC). During 1989-1992, these assessment instruments were developed by IOX Assessment Associates with the continuing collaboration of CDC personnel. The instruments were field-tested with small groups of students, then revised on the basis of students' reactions to directions, items, and vocabulary. The revised instruments were field-tested again, revised, and reviewed by individuals engaged in the evaluation of HIV education programs.

In June 1991, the contents of this booklet were reviewed by the project's national Developmental Review Panel. Modifications were made in the instruments based on the panelists' recommendations. (See the Acknowledgments in the handbook's introduction for a list of the members of the Developmental Review Panel.)

Also in June 1991, the assessment instruments were reviewed by an existing group, the national Advisory Panel convened for the broader purpose of helping CDC plan HIV evaluation activities. Appropriate modifications were made on the basis of panelists' suggestions. (See the Acknowledgments in the introduction to this handbook for a list of the members of the national Advisory Panel.)

The materials in this booklet benefitted substantially from the suggestions supplied by numerous professionals who reviewed various versions of the assessment instruments and their accompanying materials. Results should be cautiously interpreted until adequate psychometric analyses have been conducted to assess the reliability and validity of the instruments.

Organizational Preview

Each assessment instrument is preceded by important information regarding that instrument. First, a short *General Description* supplies the assessment focus of the instrument. Second, a brief *Rationale* underlying the instrument's creation is presented. Third, *Scoring Procedures* for the instrument are given. A separate one-page section entitled *Administrative Directions* provides step-by-step directions that are readily reproducible for distribution to those individuals (e.g., teachers or counselors) who will be administering the assessment instrument. Finally, there is the *assessment instrument* itself, which is also reproducible.

Securing Permission to Gather Data

Before using these instruments for evaluation purposes, you will need to obtain approval from appropriate school district authorities. A local review group consisting of educators, parents, and other citizens will often have been established to judge the acceptability of HIV education materials and instruments.

Some districts require that either *active informed consent* or *passive informed consent* be secured from parents or guardians of students prior to the administration of such assessment devices. With active informed consent, a letter is sent to a student's parents or guardians describing the general nature of the intended data gathering and asking permission for the student to complete the assessment instruments described. This letter must be signed by parents or guardians, indicating their permission to have the instruments administered to the student. With passive informed consent, a similar descriptive letter is sent to the student's parents or guardians. They are required to sign and return it, however, only if they do *not* wish the student to complete the assessment instruments. Most school districts already have policies in place regarding whether active or passive informed consent is required for data gathering.

Using the Assessment Instruments

These instruments represent a menu of assessment alternatives from which evaluators may choose. The specific timing for assessing students will depend on the particular data-gathering design employed in the evaluation study. Advice on using these instruments is provided in the handbook's first booklet, *Evaluating HIV Education Programs.*

Although the assessment instruments in this booklet were designed for use with students in grades 5-7, the vocabulary and content of each instrument may not be suitable for the students in a particular locality. If an instrument's reading level—established as late grade 5 or early grade 6—is too high for some students, it should be adjusted downward or the instrument should not be used at that grade level.

These assessment instruments were developed to supply information about HIV education programs, *not about individual students.* Therefore, the instruments in this booklet should not be used to draw inferences about a specific student's risk status. Group scores should be considered in aggregate (e.g., group means or medians).

To enhance the truthfulness of students' responses, the assessment instruments in this booklet are to be administered anonymously. However, the instruments can often yield more useful evaluative insights if two or more instruments completed by the same person can be compared. To preserve students' anonymity and, at the same time, to permit between-instrument analyses, two or more instruments can be placed in a single test-administration package.

Knowing About HIV and AIDS

Assessment Focus: HIV and AIDS knowledge related to HIV-risk behaviors

General Description

This 15-item instrument measures functional knowledge about HIV and AIDS. It can be used to measure the accuracy of students' knowledge about HIV and AIDS, or it can be used to measure students' confidence in their knowledge of HIV and AIDS.

Rationale

Functional knowledge about AIDS and HIV is knowledge that is necessary to reduce the risk of HIV transmission. Items regarding more general knowledge about HIV and AIDS, such as items about how HIV affects the immune system, were not included because of the unclear relationship of such knowledge to someone's risk behaviors.

The test is offered in two versions that have comparable content. Either form may be used for a pretest, leaving the other for a posttest.

This assessment device contains a number of items that accentuate the difference between HIV and AIDS. The emphasis on this distinction was deliberately adopted on the grounds that an effective HIV education program will, among other outcomes, help students understand the difference between AIDS and HIV infection.

Scoring Procedures

This instrument can be scored either for knowledge or for confidence in one's knowledge. Descriptions of the two methods are provided below.

Method 1

To score this instrument for *knowledge*, consider only whether the participants indicate that an item is true, false, or that they do not know whether it is true or false. The confidence of a respondent is ignored for the purposes of obtaining a knowledge score. Each correct answer receives one point (regardless of degree of confidence). For example, a false statement would be scored as correct (and the student given one point) if the student answered either "I think it's false," or "I am sure it's false." Incorrect or "don't know" answers do not receive points.

If a statement is true, points are assigned to responses as follows (for false statements, the points are reversed, with "I don't know" remaining at 0):

1 point – I am sure it's true.
1 point – I think it's true.
0 points – I don't know.
0 points – I think it's false.
0 points – I am sure it's false.

Total scores can range from 0 points (no items correct) to 15 points (all items correct).

Scoring Key

Form A:

True:	2, 3, 4, 8, 9, 10, 12
False:	1, 5, 6, 7, 11, 13, 14, 15

Form B:

True:	3, 4, 7, 9, 10, 12, 15
False:	1, 2, 5, 6, 8, 11, 13, 14

An item-by-item analysis of the group's responses can help identify those content areas that may require targeted instruction.

Method 2

To score this instrument for *confidence* in correctly held knowledge about HIV and AIDS, assign 1 to 5 points for each item. The highest number of points possible is assigned to an item that an individual answers correctly and with a high degree of confidence. Responses indicating a lower degree of confidence in a correct answer, "don't knows," and incorrect answers receive a lower number of points.

If a statement is true, points are assigned to responses as follows (for false statements, the points are reversed):

5 points – I am sure it's true.
4 points – I think it's true.
3 points – I don't know.
2 points – I think it's false.
1 point – I am sure it's false.

"Don't know" responses receive more points than incorrect answers because incorrect knowledge is potentially more damaging than uncertainty regarding the correct answer. Further, individuals with confidence in an incorrect answer may be more likely to act on their erroneous information than others who have little confidence or do not know the correct answer.

Total scores for confidence in correctly held knowledge can range from 15 points (all answers incorrect, with a high degree of confidence) to 75 points (all answers correct, with a high degree of confidence). Please refer to the scoring key on the previous page for the true and false answer key. A comparison of the group's mean total score can be used to determine changes in confidence in correctly held knowledge from pretest to posttest. In addition, an item-by-item analysis of the group's responses can help identify those content areas that may require targeted instruction.

If the instrument is scored with this method, it is important to clearly indicate this fact in reports that are produced. Otherwise, reported results may be misinterpreted. When presenting results, use phrasing similar to the following:

> Besides being scored for AIDS and HIV knowledge, the instrument was also scored to determine respondents' confidence in correctly held knowledge. Items answered correctly and with a high degree of confidence received the most points (5), and items answered incorrectly and with a high degree of confidence received the lowest number of points (1).

Knowing About HIV and AIDS

Administration Directions

Note to users of the *Knowing About HIV and AIDS* test:

Please carefully follow the administrative directions below. These directions contain information essential to the accurate completion of the survey. Thank you for your cooperation.

Directions:

1. Remind students that they are *not* to write their names on the survey. Explain that the survey is anonymous.

2. Distribute surveys to students.

3. *Read aloud* to students the directions from the front page of the survey and tell students to follow along as you read.

4. Inform students that to increase their privacy, you will not be walking around the room while they complete their surveys.

5. Tell students to place their completed surveys in a large manila envelope or box *when everyone has finished.*

6. Ask if students have any questions about how to complete the survey. Answer these questions, then have students complete the survey.

7. When students are finished, make sure they place their anonymous surveys in the container you have provided for that purpose.

8. Because students may believe that some of the false statements are, in fact, true, some educators suggest that the correct answers be discussed with students as soon as possible following the instrument's completion.

KNOWING ABOUT HIV AND AIDS

DO NOT put your name on this survey. Your answers will be kept secret. No one will know how you answered these questions.

DIRECTIONS: Read each question. Carefully check the one answer that fits best.

	I am sure it's true.	I think it's true.	I don't know.	I think it's false.	I am sure it's false.
1. Hugging a person with AIDS is a way to get HIV.	( )	( )	( )	( )	( )
2. The virus that causes AIDS is found in blood.	( )	( )	( )	( )	( )
3. You do not get HIV by using a public sink to wash your hands.	( )	( )	( )	( )	( )
4. Teenagers can get AIDS.	( )	( )	( )	( )	( )
5. Eating food made by a person with AIDS can give you HIV.	( )	( )	( )	( )	( )
6. You can get HIV by using the same telephone as a person with AIDS.	( )	( )	( )	( )	( )
7. You can tell whether people are infected with HIV by looking at them.	( )	( )	( )	( )	( )
8. Having sexual intercourse is a way to get HIV.	( )	( )	( )	( )	( )

(Form A)

Please go on to the next page. ➡

	I am sure it's true.	I think it's true.	I don't know.	I think it's false.	I am sure it's false.
9. You do not get HIV by swimming in a public swimming pool.	( )	( )	( )	( )	( )
10. Sharing needles to take steroids is one way to get HIV.	( )	( )	( )	( )	( )
11. Only boys and men get HIV.	( )	( )	( )	( )	( )
12. HIV is not spread by fleabites.	( )	( )	( )	( )	( )
13. Dancing with a person who has AIDS is a way to get HIV.	( )	( )	( )	( )	( )
14. As soon as people get HIV, they begin to feel sick.	( )	( )	( )	( )	( )
15. Condoms are 100% effective in preventing HIV.	( )	( )	( )	( )	( )

KNOWING ABOUT HIV AND AIDS

DO NOT put your name on this survey. Your answers will be kept secret. No one will know how you answered these questions.

DIRECTIONS: Read each question. Carefully check the one answer that fits best.

		I am sure it's true.	I think it's true.	I don't know.	I think it's false.	I am sure it's false.
1.	You can get HIV from sitting next to a person with AIDS.	( )	( )	( )	( )	( )
2.	People who have HIV usually look very thin and sickly.	( )	( )	( )	( )	( )
3.	A person can get HIV by sharing drug needles.	( )	( )	( )	( )	( )
4.	No one has ever gotten HIV by shaking hands with a person who has AIDS.	( )	( )	( )	( )	( )
5.	Girls and women do not get HIV.	( )	( )	( )	( )	( )
6.	A person can get HIV by using a public toilet.	( )	( )	( )	( )	( )
7.	A person can have HIV and feel healthy.	( )	( )	( )	( )	( )
8.	You can get HIV by drinking from a water fountain.	( )	( )	( )	( )	( )

Please go on to the next page. ➡

	I am sure it's true.	I think it's true.	I don't know.	I think it's false.	I am sure it's false.
9. Using condoms helps protect against HIV.	( )	( )	( )	( )	( )
10. No matter how old people are, they can get HIV.	( )	( )	( )	( )	( )
11. Sharing a soft drink with a person who has AIDS is one way to get HIV.	( )	( )	( )	( )	( )
12. At this time, there is no cure for AIDS.	( )	( )	( )	( )	( )
13. If you touch a person with AIDS, you can get HIV.	( )	( )	( )	( )	( )
14. You can get HIV if a person with AIDS sneezes on you.	( )	( )	( )	( )	( )
15. Children can be born with HIV if their mothers have HIV.	( )	( )	( )	( )	( )

How Would You Feel?

Assessment Focus: Attitudes toward people with AIDS

General Description

This 10-item instrument measures students' acceptance of, and attitudes toward, people who have AIDS. Students are asked to respond to each statement on a 5-point "comfort" scale.

Rationale

In recent years, people who have AIDS or are infected with HIV have often been stigmatized by mainstream society. Intolerant attitudes toward these people often lead to intolerant behaviors toward them. Changing such attitudes is thus a key objective in many HIV education programs.

All items use the term "AIDS" rather than "HIV" because the instrument will often be used as a pretest, prior to an instructional program in which the distinction between AIDS and HIV is explained to students. It was feared that references to people "infected with HIV" might be misunderstood by respondents and that, as a consequence, their responses to the statements might lead to inaccurate pretest-to-posttest comparisons.

Scoring Procedures

To obtain a total score, add points across all responses. Total scores can range from 30 points (indicating high acceptance of people with AIDS) to 10 points (indicating low acceptance of people with AIDS). The higher the scores, the more accepting students' attitudes are toward persons who have AIDS. Points are assigned to response options as follows:

Completely Comfortable	3 points
Somewhat Comfortable	2 points
Not at All Comfortable	1 points

How Would You Feel?

Administration Directions

Note to users of the *How Would You Feel?* survey:

Please carefully follow the administrative directions below. These directions contain information essential to the accurate completion of the survey. Thank you for your cooperation.

Directions:

1. Remind students that they are *not* to write their names on the surveys. Explain that the survey is anonymous.
2. Distribute surveys to students.
3. *Read aloud* to students the directions from the front page of the survey and tell students to follow along as you read.
4. Show students how the "Not at All Comfortable" and "Completely Comfortable" responses in the examples have been circled.
5. Inform students that to increase their privacy, you will not be walking around the room while they complete their surveys.
6. Tell students to place their completed surveys in a large manila envelope or box *when everyone has finished.*
7. Ask if students have any questions about how to complete the survey. Answer these questions, then have students complete the survey.
8. When students are finished, make sure they place their anonymous surveys in the container you have provided for that purpose.

HOW WOULD YOU FEEL?

DO NOT put your name on this survey. Your responses will be kept secret. No one will know how you answered these questions.

DIRECTIONS: These questions ask you about how comfortable you would feel in a situation. Read each question. Circle the answer that shows how you would feel.

Examples:

		Completely Comfortable C	*Somewhat Comfortable* S	*Not at All Comfortable* N
1.	How comfortable would you feel giving a speech in class?	C	S	[✓ N]
2.	How comfortable would you feel hugging a friend of yours who was feeling sad?	[✓ C]	S	N

Please go on to the next page. ➡

		Completely Comfortable C	*Somewhat Comfortable* S	*Not at All Comfortable* N
1.	How comfortable would you feel being in the same classroom with someone who has AIDS?	C	S	N
2.	How comfortable would you feel eating in the same lunchroom with someone who has AIDS?	C	S	N
3.	How comfortable would you feel hugging a close friend who has AIDS?	C	S	N
4.	How comfortable would you feel swimming in a pool with someone who has AIDS?	C	S	N
5.	How comfortable would you feel being around a classmate who you think might have AIDS?	C	S	N
6.	How comfortable would you feel staying friends with someone who has AIDS?	C	S	N
7.	How comfortable would you feel kissing a good friend or relative who has AIDS?	C	S	N
8.	How comfortable would you feel having a teacher who has AIDS?	C	S	N
9.	How comfortable would you feel making friends with someone who has AIDS?	C	S	N
10.	How comfortable would you feel playing sports with someone who has AIDS?	C	S	N

Your Attitudes

Assessment Focus: Three attitudinal dimensions related to HIV-risk behaviors

General Description

This 15-item instrument measures students' attitudes across three dimensions that are potentially related to whether a student might engage in HIV-risk behaviors. Students will indicate their degree of agreement or disagreement with each statement on a 5-point scale. The three dimensions addressed in the instrument are (1) attitudes about peer pressure, (2) attitudes about abstinence, and (3) attitudes about condom use.

Rationale

It has been well established in a variety of behavioral arenas that people's attitudes influence their behavior. In many HIV education programs, therefore, substantial energy is devoted to nurturing student attitudes that will disincline students to engage in high-risk behaviors.

Scoring Procedures

This instrument will yield a total score and a subscore for each of the three dimensions. The total score ranges from 15 points to 75 points. The scores on each dimension range from 5 points to 25 points. Higher scores reflect attitudes generally sought in HIV education programs.

Each dimension is assessed with the following items:

Dimension	Items
Attitudes about Peer Pressure	1, 4, 7, 10, 13
Attitudes about Abstinence	2, 5, 8, 11, 14
Attitudes about Condom Use	3, 6, 9, 12, 15

Scoring Key

The scale of Strongly Agree = 5, Agree = 4, Not Sure = 3, Disagree = 2, and Strongly Disagree = 1 should be used to score the following items:

1, 3, 5, 7, 8, 11, 13, 15

The scale of Strongly Agree = 1, Agree = 2, Not Sure = 3, Disagree = 4, and Strongly Disagree = 5 should be used to score the following items:

2, 4, 6, 9, 10, 12, 14

Your Attitudes

Administration Directions

Note to users of the *Your Attitudes* survey:

Please carefully follow the administrative directions below. These directions contain information essential to the accurate completion of the survey. Thank you for your cooperation.

Directions:

1. Remind students that they are *not* to write their names on the survey. Explain that the survey is anonymous.
2. Distribute surveys to students.
3. *Read aloud* to students the directions from the front page of the survey and tell students to follow along as you read.
4. Show students how the "Agree" and "Strongly Disagree" responses have been circled in the examples.
5. Inform students that to increase their privacy, you will not be walking around the room while they complete their surveys.
6. Tell students to place their completed surveys in a large manila envelope or box *when everyone has finished.*
7. Ask if students have any questions about how to complete the survey. Answer these questions, then have students complete the survey.
8. When students are finished, make sure they place their anonymous surveys in the container you have provided for that purpose.

YOUR ATTITUDES

DO NOT put your name on this survey. Your responses will be kept secret. No one will know how you answered these questions.

DIRECTIONS: This survey asks you to say whether you agree or disagree with a set of statements. Please read each statement, then indicate whether you Strongly Agree (SA), Agree (A), are Not Sure (NS), Disagree (D), or Strongly Disagree (SD) by circling the letters you want. There are no right or wrong answers. We want to know how you truly feel.

Examples:

		Strongly Agree SA	*Agree* A	*Not Sure* NS	*Disagree* D	*Strongly Disagree* SD
1.	Teenagers should eat three balanced meals each day.	SA	[✓ A]	NS	D	SD
2.	Teenagers should watch less television.	SA	A	NS	D	[✓ SD]

BEFORE STARTING, PLEASE READ THIS: Some of the statements in this survey say "having sex." This means having sexual intercourse.

Please go on to the next page. ➡

		Strongly Agree SA	*Agree* A	*Not Sure* NS	*Disagree* D	*Strongly Disagree* SD
1.	If your friends want you to do something that you think isn't safe, you should refuse.	SA	A	NS	D	SD
2.	People who don't have sex before they get married are strange.	SA	A	NS	D	SD
3.	It is really stupid for teenagers to have sex without using a condom.	SA	A	NS	D	SD
4.	To keep your friends, you should go along with most things your friends want you to do.	SA	A	NS	D	SD
5.	It's okay not to have sex while you are a teenager.	SA	A	NS	D	SD
6.	People who use condoms during sex don't trust the person they're with.	SA	A	NS	D	SD
7.	Teenagers should learn how to resist pressures from their friends.	SA	A	NS	D	SD
8.	Having sex when you are a teenager could be a big mistake.	SA	A	NS	D	SD
9.	It's okay for a teenager to have sex without a condom if the teenager knows his/her partner well.	SA	A	NS	D	SD
10.	It may be worth doing some dangerous things in order to be popular.	SA	A	NS	D	SD
11.	It's a good idea for teenagers to choose not to have sex.	SA	A	NS	D	SD

Please go on to the next page. ➡

		Strongly Agree SA	*Agree* A	*Not Sure* NS	*Disagree* D	*Strongly Disagree* SD
12.	It's embarrassing to talk about condoms.	SA	A	NS	D	SD
13.	Teenagers should resist pressure from their friends to have sex.	SA	A	NS	D	SD
14.	Teenagers who don't have sex are wasting their teen years.	SA	A	NS	D	SD
15.	If people think they might have sex during a date, they should carry a condom.	SA	A	NS	D	SD

How Sure Are You?

Assessment Focus: Confidence in one's ability to resist peer pressures

General Description

This 10-item instrument measures students' confidence in their ability to resist peer pressures. The instrument attempts to assess students' refusal skills in age-appropriate social situations.

Rationale

Peer expectations influence the decisions that people make in social situations. Resisting pressure from friends and acquaintances can play an important part in avoiding an uncomfortable or risky situation. In many HIV education programs, students are taught to use refusal skills to avoid situations that put them at risk for HIV infection.

This instrument measures how sure students are that they could refuse their friends in order to avoid an uncomfortable or risky situation. Experience in resisting peer pressure in situations such as these may later help students avoid situations that place them at risk of HIV infection. The focus on students' confidence (how sure they are) was employed in this instrument because research suggests that confidence in one's ability to use a skill (for example, a refusal skill) may be a particularly important factor contributing to one's actual use of that skill.

Scoring Procedures

Points are assigned to response options as follows:

Completely Sure	3 points
Somewhat Sure	2 points
Not at All Sure	1 point

Total scores can range from 30 points (indicating a high degree of confidence) to 10 points (indicating a low degree of confidence). An item-by-item analysis of a groups' responses to this survey may reveal the types of social settings that should be addressed instructionally to help students resist peer pressures.

How Sure Are You?

Administration Directions

Note to users of the *How Sure Are You?* survey:

Please carefully follow the administrative directions below. These directions contain information essential to the accurate completion of the survey. Thank you for your cooperation.

Directions:

1. Remind students that they are *not* to write their names on the survey. Explain that the survey is anonymous.
2. Distribute surveys to students.
3. *Read aloud* to students the directions from the front page of the survey and tell students to follow along as you read.
4. Show students how the "Completely Sure" and "Not at All Sure" responses have been circled in the examples.
5. Inform students that to increase their privacy, you will not be walking around the room while they complete their surveys.
6. Tell students to place their completed surveys in a large manila envelope or box *when everyone has finished.*
7. Ask if students have any questions about how to complete the survey. Answer these questions, then have students complete the survey.
8. When students are finished, make sure they place their anonymous surveys in the container you have provided for that purpose.

HOW SURE ARE YOU?

DO NOT put your name on this survey. Your answers will be kept secret. No one will know how you answered these questions.

DIRECTIONS: Read each situation. *Try to imagine yourself in the situation.* Circle the answer that fits best.

Examples:

		Completely Sure C	*Somewhat Sure* S	*Not at All Sure* N
1.	Some boys and girls in your school want you to help them spray-paint the sidewalks around school tonight. *If you didn't want to help them spray-paint*, how sure are you that you could refuse?	C	S	[✓ N]
2.	Your friends have asked you to leave the school grounds at noontime even though it's against school rules. *If you didn't want to go with them*, how sure are you that you could refuse?	[✓ C]	S	N

Please go on to the next page. ➡

		Completely Sure C	*Somewhat Sure* S	*Not at All Sure* N
1.	A group of your friends are going to a scary movie and invite you to come. You don't like scary movies. Your friends make fun of you. *If you didn't want to go to the movie with your friends*, how sure are you that you could refuse?	C	S	N
2.	You are with a group of your friends at a mall one day after school. One of your friends has some marijuana and suggests that you all find somewhere to smoke it together. You've never tried marijuana before. Everyone else smokes some and they dare you to try it. *If you didn't want to try the marijuana*, how sure are you that you could refuse?	C	S	N
3.	Your parents have gone out for the evening and have told you to stay at home. A good friend calls you and asks you to come over. Your parents let you go to this friend's house at other times, but you know you'll be in trouble if you go tonight. Your friend insists that your parents will never find out. *If you didn't want to go to your friend's house*, how sure are you that you could refuse?	C	S	N
4.	While walking home from school one afternoon, you see a friend you've had a crush on for a while. The two of you talk alone for a few minutes, and your friend tries to kiss you. You don't feel ready to kiss your friend yet. *If you didn't want to kiss your friend*, how sure are you that you could refuse?	C	S	N

Please go on to the next page. →

		Completely Sure C	*Somewhat Sure* S	*Not at All Sure* N
5.	You are walking home after a very long day at school. Your best friend suggests you go to the store and get a soft drink together, but your parents told you to come straight home. You know your friend will get mad if you don't go. *If you decided not to go with your friend*, how sure are you that you could refuse?	C	S	N
6.	You are at a party at a friend's house. Your friend's parents aren't home. Someone finds a can of beer, opens it, takes a drink, and passes it around. Everyone has some. You're afraid that your friends will think you're scared. *If you didn't want to have any beer*, how sure are you that you could refuse?	C	S	N
7.	You are shopping at a store with some friends who pick up candy bars and hide them in their pockets. They say it's fun and want you to take something, too. You don't think you should, but you want to be part of the group. *If you didn't want to take anything from the store*, how sure are you that you could refuse?	C	S	N
8.	You are at a party at the house of a friend whose parents aren't home. Someone suggests a game where a boy and girl go into a dark "kissing closet" together for five minutes. You aren't comfortable with this game, but you don't want your friends to think you're scared. *If you didn't want to play this game*, how sure are you that you could refuse?	C	S	N

Please go on to the next page. →

		Completely Sure C	*Somewhat Sure* S	*Not at All Sure* N
9.	You have a lot of homework to do, but your friends want you to go to a movie with them. You want to go, but you really need to do your homework. You know that if they see the movie, none of them will want to go to the movie with you later in the week. *If you decided not to go with your friends*, how sure are you that you could refuse?	C	S	N
10.	A friend whom you've had a crush on calls you and asks you to come over. Your friend's parents aren't home, and you think the friend might want to make out with you. *If you didn't want to go to this friend's house*, how sure are you that you could refuse?	C	S	N

HANDBOOK OVERVIEW

This booklet is part of a series of eight booklets included in the *Handbook for Evaluating HIV Education.* The handbook contains evaluation designs and measurement tools necessary to collect data on the basic program components of policy development, curriculum design, teacher training, and student outcomes.
The eight booklets are listed below.

1. Evaluating HIV Education Programs
2. Developing and Revising HIV Policies
3. Appraising an HIV Curriculum
4. Evaluating HIV Staff Development Programs
5. **Assessment Instruments for Measuring Student Outcomes: Grades 5-7**
6. Assessment Instruments for Measuring Student Outcomes: Grades 7-12
7. Choosing and Using an External Evaluator
8. Reporting Results of HIV Education Evaluations

For further information on the use of these booklets, please contact your state HIV coordinator or your CDC project officer.

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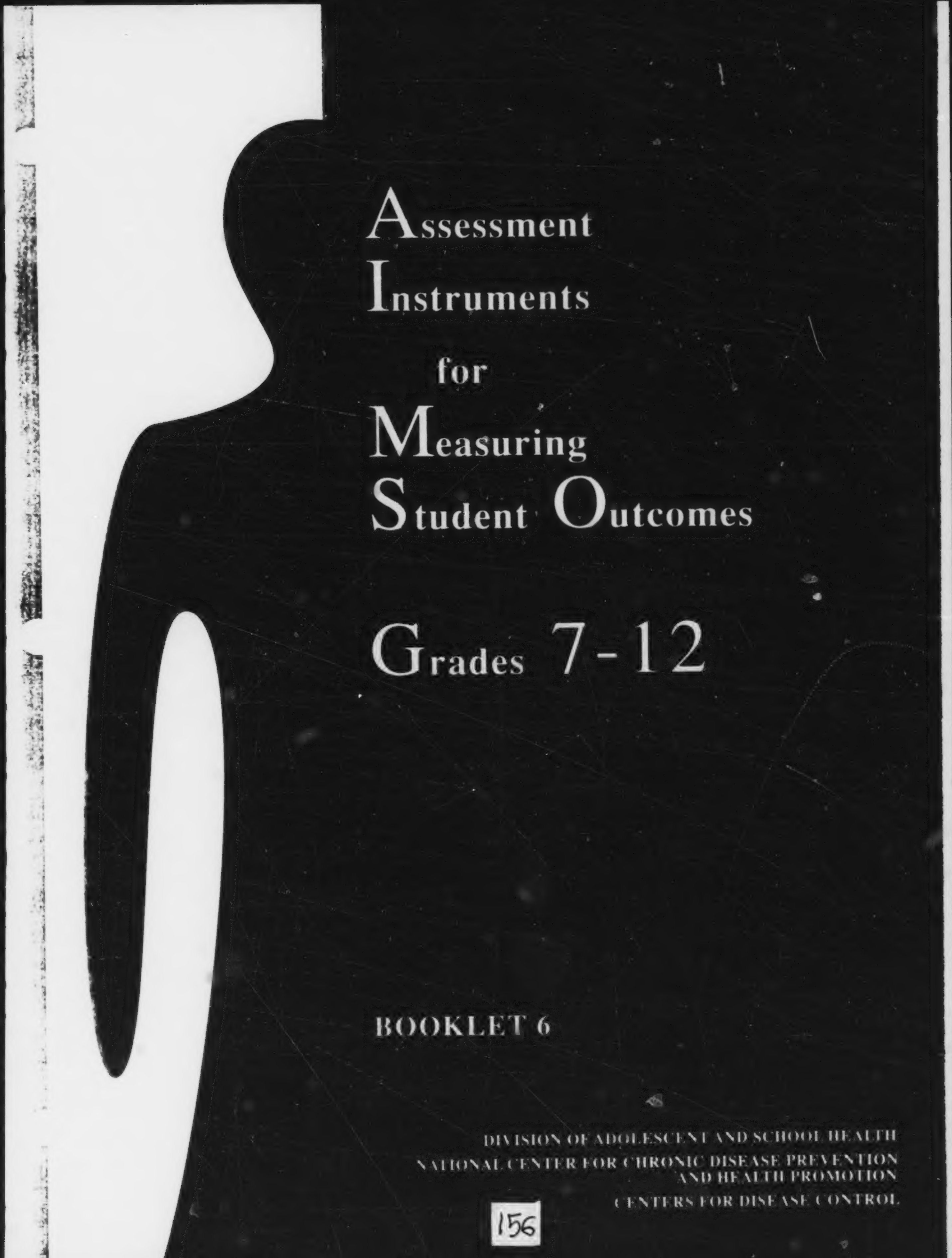

Assessment Instruments for Measuring Student Outcomes

Grades 7-12

BOOKLET 6

DIVISION OF ADOLESCENT AND SCHOOL HEALTH
NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION
AND HEALTH PROMOTION
CENTERS FOR DISEASE CONTROL

ASSESSMENT INSTRUMENTS FOR MEASURING STUDENT OUTCOMES

GRADES 7-12

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TABLE OF CONTENTS

Page

INTRODUCTION 1
Developmental History 1
Organizational Preview 2
Securing Permission to Gather Data 2
Using the Assessment Instruments 3

KNOWLEDGE OF HIV AND AIDS 5
(*Assessment Focus: HIV and AIDS knowledge related to HIV-risk behaviors*)
General Description 5
Rationale 5
Scoring Procedures 5
Administration Directions 9
The Instrument: Form A 11
The Instrument: Form B 15

YOUR BELIEFS 19
(*Assessment Focus: Attitudes toward people with AIDS*)
General Description 19
Rationale 19
Scoring Procedures 19
Administration Directions 21
The Instrument 23

YOUR VIEWS 27
(*Assessment Focus: Five attitudinal dimensions related to HIV-risk behaviors*)
General Description 27
Rationale 27
Scoring Procedures 27
Administration Directions 29
The Instrument 31

HOW CONFIDENT ARE YOU? 39
(*Assessment Focus: Confidence in one's ability to resist peer pressures*)
General Description 39
Rationale 39
Scoring Procedures 39
Administration Directions 41
The Instrument 43

YOUR FRIENDS 49
(*Assessment Focus: Perceptions of peers' behaviors and values*)
General Description 49
Rationale 49
Scoring Procedures 49
Administration Directions 51
The Instrument 53

YOUR INTENTIONS . . . 57
(*Assessment Focus: Intentions regarding HIV-risk behaviors and their precursors*)
- General Description . . . 57
- Rationale . . . 57
- Scoring Procedures . . . 57
- Administration Directions . . . 59
- The Instrument: Form K . . . 61
- The Instrument: Form L . . . 67
- The Instrument: Form M . . . 73

YOUR BEHAVIOR . . . 79
(*Assessment Focus: HIV-risk behaviors*)
- General Description . . . 79
- Rationale . . . 79
- Scoring Procedures . . . 79
- Administration Directions . . . 81
- The Instrument: Form K . . . 83
- The Instrument: Form L . . . 89
- The Instrument: Form M . . . 95

Introduction

This booklet contains a set of assessment instruments specifically developed to assist those who wish to evaluate an HIV education program. The instruments are designed to assess knowledge, attitudes, and behaviors that frequently serve as instructional targets of HIV education. The instruments are provided to offer a range of options that evaluators may wish to consider. The instruments may be used as is or may be modified to become more consistent with a particular program's instructional emphases.

The assessment instruments in this booklet were designed for students in grades 7 through 12. A companion booklet provides instruments for students in grades 5 through 7. It should be noted that at grade 7—the division point between the two sets of assessment instruments—a choice must be made between the instrument sets. Because there are substantial variations in the maturity and achievement levels of students in different locales, if the instruments are to be used with students in grades 6, 7, or 8, both sets of instruments should be reviewed to identify those most appropriate for a particular group of students.

The absence of assessment instruments for lower grades does not imply that HIV-relevant instruction should not be provided in those grades. However, because instruction in lower grades tends to deal with more general objectives such as health promotion and self-esteem, no separate set of assessment instruments was developed for those grade levels.

Developmental History

The assessment devices in this booklet were prepared as part of a project supported by the Division of Adolescent and School Health, Centers for Disease Control (CDC). During 1989-1992, these assessment instruments were developed by IOX Assessment Associates with the continuing collaboration of CDC personnel. The instruments were field-tested with small groups of students, then revised on the basis of students' reactions to directions, items, and vocabulary. The revised instruments were field-tested again, revised, and reviewed by individuals engaged in the evaluation of HIV education programs.

In June 1991, the contents of this booklet were reviewed by the project's national Developmental Review Panel. Modifications were made in the instruments based on the panelists' recommendations. (See the Acknowledgments in the handbook's introduction for a list of the members of the Developmental Review Panel.)

Also in June 1991, the assessment instruments were reviewed by an existing group, the national Advisory Panel, convened for the broader purpose of helping CDC plan HIV evaluation activities. Appropriate modifications were made on the basis of panelists' suggestions. (See the Acknowledgments in the introduction to this handbook for a list of the members of the national Advisory Panel.)

The materials in this booklet benefitted substantially from the suggestions supplied by numerous professionals who reviewed various versions of the assessment instruments and their accompanying materials. It should be noted, however, that until psychometric analyses have been conducted to determine instrument reliability and validity, caution should be exercised when interpreting data derived from these instruments.

Organizational Preview

Each assessment instrument is preceded by important information regarding the instrument. First, a short *General Description* supplies the assessment focus of the instrument. Second, a brief *Rationale* underlying the instrument's creation is presented. Third, *Scoring Procedures* for the instrument are given. A separate one-page section entitled *Administrative Directions* provides step-by-step directions that are readily reproducible for distribution to those individuals (e.g., teachers or counselors) who will be administering the assessment instrument. Finally, there is the *assessment instrument* itself, which is also reproducible.

Securing Permission to Gather Data

Before using these instruments for evaluation purposes, you will need to obtain approval from appropriate school district authorities. A local review group consisting of educators, parents, and other citizens will often have been established to judge the acceptability of HIV education materials and instruments.

Some districts require that either *active informed consent* or *passive informed consent* be secured from parents or guardians of students prior to the administration of such assessment devices. With active informed consent, a letter is sent to a student's parents or guardians describing the general nature of the intended data gathering and asking permission for the student to complete the assessment instruments described. This letter must be signed by parents or guardians, indicating their permission to have the instruments administered to the student. With passive informed consent, a similar descriptive letter is sent to the student's parents or guardians. They are required to sign and return it, however, only if they do *not* wish the student to complete the assessment instruments. Most school districts already have policies in place regarding whether active or passive informed consent is required for data gathering.

Using the Assessment Instruments

These assessment devices represent a menu of assessment alternatives from which evaluators may choose. The specific timing for assessing students will depend on the particular data-gathering design being employed in the evaluation study. Advice on using these instruments is provided in the handbook's first booklet, *Evaluating HIV Education Programs.*

These assessment instruments were developed to supply information about HIV education programs, *not individual students.* Therefore, the instruments in this booklet should not be used to draw inferences about a specific student's risk status. Group scores should be considered in aggregate (e.g., group means or medians).

To enhance the truthfulness of students' responses, the assessment instruments in this booklet are to be administered anonymously. However, the instruments can often yield more useful evaluative insights if two or more instruments completed by the same person can be compared. To preserve students' anonymity and, at the same time, to permit between-instrument analyses, two or more instruments can be placed in a single test-administration package. For example, an evaluator might staple together the behavior survey, the behavioral intention survey, and the knowledge test, then interpret the responses of a student to one instrument on the basis of the same student's responses to items on another.

Because it is necessary to maintain students' anonymity, a student's pretest and posttest responses cannot be linked without the use of elaborate coding schemes and confidentiality assurance procedures. Nonetheless, interpretive dividends can clearly be gained by administering multiple instruments at one time in a single test-administration package.

Knowledge of HIV and AIDS

Assessment Focus: HIV and AIDS knowledge related to HIV-risk behaviors

General Description

This 15-item instrument measures functional knowledge about HIV and AIDS (that is, knowledge necessary to reduce the risk of HIV infection). This instrument may be employed in two ways. It can be used to measure the accuracy of students' knowledge about HIV and AIDS, or it can be used to measure students' confidence in their knowledge of HIV and AIDS.

Rationale

This instrument measures functional knowledge about HIV and AIDS. Items regarding more general knowledge about HIV and AIDS, such as items about how HIV affects the immune system, were not included because of the unclear relationship of such knowledge to someone's risk behaviors.

The test is offered in two versions that have comparable content. Either form may be used for a pretest, leaving the other for a posttest.

This assessment device contains a number of items that accentuate the difference between HIV and AIDS. The emphasis on this distinction was deliberately adopted on the grounds that an effective HIV education program will, among other emphases, help students understand the difference between AIDS and HIV infection.

Scoring Procedures

This instrument can be scored either for knowledge or for confidence in one's knowledge. Descriptions of the two methods are provided below.

Method 1

To score this instrument for *knowledge*, consider only whether the participants indicate that an item is true, false, or that they do not know whether it is true or false. The confidence of a respondent is ignored for the purposes of obtaining a knowledge score. Each correct answer receives one point (regardless of degree of confidence). For example, a false statement would be scored as correct (and the student given one point) if the student answered either "I think it's false," or "I am sure it's false." Incorrect or "don't know" answers do not receive points.

If a statement is true, points are assigned to responses as follows (for false statements, the points are reversed, with "I don't know" remaining at 0):

1 point – I am sure it's true.
1 point – I think it's true.
0 points – I don't know.
0 points – I think it's false.
0 points – I am sure it's false.

Total scores can range from 0 points (no items correct) to 15 points (all items correct).

Scoring Key

Form A:

True:	2, 4, 6, 8, 9, 10, 11
False:	1, 3, 5, 7, 12, 13, 14, 15

Form B:

True:	3, 4, 7, 8, 9, 10, 11, 12
False:	1, 2, 5, 6, 13, 14, 15

An item-by-item analysis of the group's responses can help identify those content areas that may require targeted instruction.

Method 2

To score this instrument for *confidence* in correctly held knowledge about HIV and AIDS, assign 1 to 5 points for each item. The highest number of points possible is assigned to an item that an individual answers correctly and with a high degree of confidence. Responses indicating a lower degree of confidence in a correct answer, "don't knows," and incorrect answers receive a lower number of points.

If a statement is true, points are assigned to responses as follows (for false answers, the points are reversed):

5 points – I am sure it's true.
4 points – I think it's true.
3 points – I don't know.
2 points – I think it's false.
1 point – I am sure it's false.

"Don't know" responses receive more points than incorrect answers because incorrect knowledge is potentially more damaging than uncertainty regarding the correct answer. Further, individuals with some degree of confidence in an incorrect answer may be more likely to act on their erroneous information than others who have little confidence or do not know the correct answer.

Total scores for confidence in correctly held knowledge can range from 15 points (all answers incorrect, with a high degree of confidence) to 75 points (all items correct, with a high degree of confidence). Please refer to the scoring key on the previous page for the answer key. A comparison of the group's mean total score can be used to determine changes in confidence in correctly held knowledge from pretest to posttest. In addition, an item-by-item analysis of the group's responses can help identify those content areas that may require targeted instruction.

If the instrument is scored with this method, it is important to clearly indicate this fact in reports that are produced. Otherwise, reported results may be misinterpreted. When presenting results, use phrasing similar to the following:

> Besides being scored for AIDS and HIV knowledge, the instrument was also scored to determine respondents' confidence in correctly held knowledge. Items answered correctly and with a high degree of confidence received the most points (5), and items answered incorrectly and with a high degree of confidence received the lowest number of points (1).

Knowledge of HIV and AIDS

Administration Directions

Note to users of the *Knowledge of HIV and AIDS* test:

Please carefully follow the administrative directions below. These directions contain information essential to the accurate completion of the survey. Thank you for your cooperation.

Directions:

1. Remind students that they are *not* to write their names on the surveys. Explain that the survey is anonymous.
2. Distribute surveys to students.
3. *Read aloud* to students the directions from the front page of the survey and tell students to follow along as you read.
4. Inform students that to increase their privacy, you will not be walking around the room while they complete their surveys.
5. Tell students to place their completed surveys in a large manila envelope or box *when everyone has finished.*
6. Ask if students have any questions about how to complete the survey. Answer these questions, then have students complete the survey.
7. When students are finished, make sure they place their anonymous surveys in the container you have provided for that purpose.
8. Because students may believe that some of the false statements are, in fact, true, some educators suggest that the correct answers be discussed with students as soon as possible following the instrument's completion.

KNOWLEDGE OF HIV AND AIDS

DO NOT put your name on this survey. Your answers will be kept secret. No one will know how you answered these questions.

DIRECTIONS: Read each question. Carefully check the one answer that fits best. Some of the questions use the phrase "having sex." This means sexual intercourse.

		I am sure it's true.	I think it's true.	I don't know.	I think it's false.	I am sure it's false.
1.	You can't get AIDS if you have sex only once or twice without a condom.	( )	( )	( )	( )	( )
2.	A person can "pass" an HIV-antibody test (test negative) but still be infected with HIV.	( )	( )	( )	( )	( )
3.	Condoms are 100% effective in preventing HIV.	( )	( )	( )	( )	( )
4.	Males can pass HIV on to others through their semen.	( )	( )	( )	( )	( )
5.	You can get HIV by sitting on the seat of a toilet that a person with AIDS has used.	( )	( )	( )	( )	( )
6.	Abstinence from sex and drugs is the best way for teenagers to avoid getting HIV.	( )	( )	( )	( )	( )
7.	You can get HIV from drinking from the same glass or water fountain that a person with AIDS drank from.	( )	( )	( )	( )	( )
8.	HIV can be found in semen, vaginal fluids, and blood.	( )	( )	( )	( )	( )

(Form A)

Please go on to the next page. ➡

		I am sure it's true.	I think it's true.	I don't know.	I think it's false.	I am sure it's false.
9.	A person can get HIV by sharing drug needles.	( )	( )	( )	( )	( )
10.	HIV can be found in breast milk.	( )	( )	( )	( )	( )
11.	Once you are infected with HIV, you are infected for life.	( )	( )	( )	( )	( )
12.	People infected with HIV are usually very thin and sickly.	( )	( )	( )	( )	( )
13.	Some people have gotten HIV by swimming in the same pool as someone with AIDS.	( )	( )	( )	( )	( )
14.	You can get HIV from a mosquito bite.	( )	( )	( )	( )	( )
15.	If you want to keep from getting HIV, using "lambskin" condoms is just as good as using latex condoms.	( )	( )	( )	( )	( )

Please go on to the next page. ➡

KNOWLEDGE OF HIV AND AIDS

DO NOT put your name on this survey. Your answers will be kept secret. No one will know how you answered these questions.

DIRECTIONS: Read each question. Carefully check the one answer that fits best. Some of the questions use the phrase "having sex." This means sexual intercourse.

		I am sure it's true.	I think it's true.	I don't know.	I think it's false.	I am sure it's false.
1.	Someone with AIDS can spread HIV by coughing and spitting.	( )	( )	( )	( )	( )
2.	There is no way to kill HIV on a drug needle.	( )	( )	( )	( )	( )
3.	Females can pass HIV on to others through their vaginal fluids.	( )	( )	( )	( )	( )
4.	In the United States, your chance of getting HIV when you get a blood transfusion is extremely small.	( )	( )	( )	( )	( )
5.	You can get HIV from being in a swimming pool.	( )	( )	( )	( )	( )
6.	There is no way you can find out if you are infected with HIV.	( )	( )	( )	( )	( )
7.	You can get infected with HIV by having sex with someone who shares drug needles.	( )	( )	( )	( )	( )
8.	Mosquitos don't spread HIV.	( )	( )	( )	( )	( )
9.	It is not dangerous to hug a person with AIDS.	( )	( )	( )	( )	( )
10.	One way to avoid getting HIV is by not having sex.	( )	( )	( )	( )	( )

(Form B)

Please go on to the next page. ⇒

		I am sure it's true.	I think it's true.	I don't know.	I think it's false.	I am sure it's false.
11.	"Lambskin" condoms do not protect against HIV as well as latex condoms do.	( )	( )	( )	( )	( )
12.	People infected with HIV do not necessarily look sick.	( )	( )	( )	( )	( )
13.	You can be cured of HIV if you are careful to take the medicine the doctor gives you.	( )	( )	( )	( )	( )
14.	You can't get HIV from sharing needles for tattoos.	( )	( )	( )	( )	( )
15.	The breast milk of a mother who has HIV is safe for her baby.	( )	( )	( )	( )	( )

Your Beliefs

Assessment Focus: Attitudes toward people with AIDS

General Description

This 10-item instrument measures students' acceptance of and attitudes toward people who have AIDS. Students are asked to respond to each statement on a 5-point "agreement" scale.

Rationale

In recent years, people who have AIDS or are infected with HIV have often been stigmatized by mainstream society. Intolerant attitudes toward these people often lead to intolerant behaviors toward them. Changing such attitudes among students is thus a key objective in many HIV education programs.

All items use the term "AIDS" rather than "HIV" because the instrument will often be used as a pretest prior to an instructional program in which the distinction between AIDS and HIV is explained to students. It was feared that references to people "infected with HIV" might be misunderstood by respondents and that, as a consequence, their responses to the statements might lead to inaccurate pretest-to-posttest comparisons.

Scoring Procedures

To obtain a total score, add points across all responses. Total scores can range from 50 points (indicating high acceptance of people with AIDS) to 10 points (indicating low acceptance of people with AIDS). The higher the scores, the more accepting students' attitudes are toward persons who have AIDS.

The following scale should be used to score items 1, 3, 4, 5, and 8:

Strongly Agree	5 points
Agree	4 points
Not Sure	3 points
Disagree	2 points
Strongly Disagree	1 point

The following scale should be used to score items 2, 6, 7, 9, and 10:

Strongly Agree	1 point
Agree	2 points
Not Sure	3 points
Disagree	4 points
Strongly Disagree	5 points

Your Beliefs

Administration Directions

Note to users of the *Your Beliefs* survey:

Please carefully follow the administrative directions below. These directions contain information essential to the accurate completion of the survey. Thank you for your cooperation.

Directions:

1. Remind students that they are *not* to write their names on the surveys. Explain that the survey is anonymous.
2. Distribute surveys to students.
3. *Read aloud* to students the directions from the front page of the survey and tell students to follow along as you read.
4. Show students how "Strongly Agree" and "Disagree" have been circled in the examples.
5. Inform students that to increase their privacy, you will not be walking around the room while they complete their surveys.
6. Tell students to place their completed surveys in a large manila envelope or box *when everyone has finished.*
7. Ask if students have any questions about how to complete the survey. Answer these questions, then have students complete the survey.
8. When students are finished, make sure they place their anonymous surveys in the container you have provided for that purpose.

YOUR BELIEFS

DO NOT put your name on this survey. Your responses will be kept secret. No one will know how you answered these questions.

DIRECTIONS: This survey asks you to say whether you agree or disagree with a set of statements. Please read each statement, then indicate whether you Strongly Agree (SA), Agree (A), are Not Sure (NS), Disagree (D), or Strongly Disagree (SD) by circling the answer you want.

Examples:

	Strongly Agree SA	*Agree* A	*Not Sure* NS	*Disagree* D	*Strongly Disagree* SD
1. People should eat a nutritious breakfast to give them energy through the morning.	[✓ SA]	A	NS	D	SD
2. Teenagers don't need more than five hours of sleep each night.	SA	A	NS	[✓ D]	SD

Please go on to the next page. ⇒

	Strongly Agree SA	*Agree* A	*Not Sure* NS	*Disagree* D	*Strongly Disagree* SD
1. I wouldn't mind being in the same classroom with someone who has AIDS.	SA	A	NS	D	SD
2. A person who has AIDS shouldn't be allowed to eat lunch in the school cafeteria.	SA	A	NS	D	SD
3. I would feel comfortable hugging a close friend who has AIDS.	SA	A	NS	D	SD
4. I wouldn't mind swimming in the same pool as someone who has AIDS.	SA	A	NS	D	SD
5. I wouldn't mind playing sports with someone who has AIDS.	SA	A	NS	D	SD
6. A person who has AIDS should stay away from public places.	SA	A	NS	D	SD
7. I would avoid a classmate who I heard had AIDS.	SA	A	NS	D	SD
8. People who have AIDS should be allowed to work in restaurants and cafeterias.	SA	A	NS	D	SD
9. If I thought my friend had AIDS, I would be afraid to give that friend a kiss.	SA	A	NS	D	SD
10. I would avoid a classmate whose family member had AIDS.	SA	A	NS	D	SD

Your Views

Assessment Focus: Five attitudinal dimensions related to HIV-risk behaviors

General Description

This 25-item instrument measures students' attitudes across five dimensions that are potentially related to whether a student might engage in HIV-risk behaviors. Students will use a 5-point scale to indicate their degree of agreement or disagreement with each statement. The five dimensions addressed in the instrument are attitudes regarding (1) peer pressure, (2) abstinence, (3) condom use, (4) drugs and steroids, and (5) the threat of HIV infection.

Rationale

It has been well established in a variety of behavioral arenas that peoples' attitudes influence their behavior. In many HIV education programs, therefore, substantial energy is devoted to nurturing student attitudes that will disincline students to engage in high-risk behaviors.

If one or more of the five dimensions assessed in this instrument are not seriously addressed in a particular HIV education program, it is relatively simple to remove the relevant set(s) of items from the instrument.

Scoring Procedures

This instrument will yield a total score and a subscore for each of the five dimensions. The total score ranges from 25 points to 125 points. The scores on each dimension range from 5 points to 25 points. Higher scores reflect attitudes generally sought in HIV education programs. Each dimension is assessed with the following items:

Dimension	Items
Attitudes about Peer Pressure	1, 6, 11, 15, 19
Attitudes about Abstinence	2, 7, 12, 20, 22
Attitudes about Condom Use	3, 8, 16, 21, 23
Attitudes about Drugs and Steroids	4, 9, 13, 17, 24
Attitudes about Threat of HIV Infection	5, 10, 14, 18, 25

Scoring Key

The scale of Strongly Agree = 5, Agree = 4, Not Sure = 3, Disagree = 2, and Strongly Disagree = 1 should be used to score the following items:

2, 5, 8, 9, 11, 12, 14, 17, 19, 20, 21, 24, 25

The scale of Strongly Agree = 1, Agree = 2, Not Sure = 3, Disagree = 4, and Strongly Disagree = 5 should be used to score the following items:

1, 3, 4, 6, 7, 10, 13, 15, 16, 18, 22, 23

Your Views

Administration Directions

Note to users of the *Your Views* survey:

Please carefully follow the administrative directions below. These directions contain information essential to the accurate completion of the survey. Thank you for your cooperation.

Directions:

1. Remind students that they are *not* to write their names on the surveys. Explain that the survey is anonymous.

2. Distribute surveys to students.

3. *Read aloud* to students the directions from the front page of the survey and tell students to follow along as you read.

4. Show students how the "Agree" and "Strongly Disagree" responses have been circled in the examples.

5. Inform students that to increase their privacy, you will not be walking around the room while they complete their surveys.

6. Tell students to place their completed surveys in a large manila envelope or box *when everyone has finished.*

7. Ask if students have any questions about how to complete the survey. Answer these questions, then have students complete the survey.

8. When students are finished, make sure they place their anonymous surveys in the container you have provided for that purpose.

YOUR VIEWS

DO NOT put your name on this survey. Your responses will be kept secret. No one will know how you answered these questions.

DIRECTIONS: This survey asks you to say whether you agree or disagree with a set of statements. Please read each statement, then indicate whether you Strongly Agree (SA), Agree (A), are Not Sure (NS), Disagree (D), or Strongly Disagree (SD) by circling the answer you want.

Examples:

		Strongly Agree SA	*Agree* A	*Not Sure* NS	*Disagree* D	*Strongly Disagree* SD
1.	Teenagers should eat three balanced meals each day.	SA	[✓ A]	NS	D	SD
2.	Teenagers should watch less television.	SA	A	NS	D	[✓ SD]

BEFORE STARTING, PLEASE READ THE FOLLOWING: Some of the statements in this survey use the phrase "having sex." This means having sexual intercourse. There are also statements about HIV. HIV is the virus that causes AIDS.

Please go on to the next page. ⇒

		Strongly Agree SA	*Agree* A	*Not Sure* NS	*Disagree* D	*Strongly Disagree* SD
1.	If your friends want you to do something that you think might not be safe, you should at least try it.	SA	A	NS	D	SD
2.	It's okay not to have sex while you are a teenager.	SA	A	NS	D	SD
3.	It's okay for teenagers to have sex without a condom if they know each other well.	SA	A	NS	D	SD
4.	A teenager can inject drugs once in a while without a risk of getting infected with HIV.	SA	A	NS	D	SD
5.	Teenagers are at risk of getting infected with HIV if they engage in sex without a condom.	SA	A	NS	D	SD
6.	To keep your friends, you should go along with most things your friends want you to do.	SA	A	NS	D	SD
7.	People who don't have sex before they get married are strange.	SA	A	NS	D	SD
8.	It is not smart to have sex without using a condom.	SA	A	NS	D	SD
9.	Using needles to inject steroids or drugs is a bad idea.	SA	A	NS	D	SD
10.	It's okay to have sex without a condom because your chance of getting infected with HIV is very low.	SA	A	NS	D	SD
11.	Teenagers should learn how to resist pressures from their friends.	SA	A	NS	D	SD
12.	It's a good idea for teenagers not to have sex.	SA	A	NS	D	SD

Please go on to the next page. ⇒

		Strongly Agree SA	*Agree* A	*Not Sure* NS	*Disagree* D	*Strongly Disagree* SD
13.	People who share drug needles shouldn't worry because they probably won't get infected with HIV.	SA	A	NS	D	SD
14.	Teenagers should realize that if they're not careful, they could get infected with HIV.	SA	A	NS	D	SD
15.	When friends want you to do things you don't feel like doing, there's no harm in going along.	SA	A	NS	D	SD
16.	Using a condom doesn't make sex less pleasurable.	SA	A	NS	D	SD
17.	Anyone who shares needles is taking a chance of getting infected with HIV.	SA	A	NS	D	SD
18.	If teenagers are careful about choosing sexual partners, they won't get infected with HIV.	SA	A	NS	D	SD
19.	Teenagers should be more willing to resist pressures from their friends.	SA	A	NS	D	SD
20.	These days it makes a lot of sense to wait to have sex until you get married.	SA	A	NS	D	SD
21.	If people think they might have sex during a date, they should carry a condom.	SA	A	NS	D	SD
22.	Teenagers who don't have sex are wasting their teen years.	SA	A	NS	D	SD
23.	People who use condoms during sex don't trust the person they're with.	SA	A	NS	D	SD

Please go on to the next page. ⇒

		Strongly Agree SA	*Agree* A	*Not Sure* NS	*Disagree* D	*Strongly Disagree* SD
24.	People who share drug needles should clean the needles with bleach.	SA	A	NS	D	SD
25.	HIV is something that teenagers should think about when they date.	SA	A	NS	D	SD

How Confident Are You?

Assessment Focus: Confidence in one's ability to resist peer pressures

General Description

This 10-item instrument measures students' confidence in their ability to resist peer pressures. The instrument attempts to assess students' refusal skills in age-appropriate social situations.

Rationale

Peer expectations influence the decisions that people make in social situations. Resisting pressure from friends and acquaintances can play an important part in avoiding an uncomfortable or risky situation. In many HIV education programs, students are taught to use refusal skills in order to avoid situations that put them at risk for HIV infection.

This instrument measures how confident students are that they could refuse their friends in order to avoid an uncomfortable or risky situation. The focus on students' confidence was employed in this instrument because research suggests that confidence in one's ability to use a skill (for example, a refusal skill) may be a particularly important factor contributing to one's actual use of that skill.

Scoring Procedures

Points are assigned to response options as follows:

Completely Confident	5
Very Confident	4
Somewhat Confident	3
Not Very Confident	2
Not Confident at All	1

Total scores range from 50 points (indicating a high degree of confidence) to 10 points (indicating a low degree of confidence). An item-by-item analysis of a group's responses to this survey may reveal the types of social settings that should be addressed instructionally to help students resist peer pressure.

How Confident Are You?

Administration Directions

Note to users of the *How Confident Are You?* survey:

Please carefully follow the administrative directions below. These directions contain information essential to the accurate completion of the survey. Thank you for your cooperation.

Directions:

1. Remind students that they are *not* to write their names on the surveys. Explain that the survey is anonymous.
2. Distribute surveys to students.
3. *Read aloud* to students the directions from the front page of the survey and tell students to follow along as you read.
4. Show students how the "Not Very Confident" response has been marked with an X in the example.
5. Inform students that to increase their privacy, you will not be walking around the room while they complete their surveys.
6. Tell students to place their completed surveys in a large manila envelope or box *when everyone has finished.*
7. Ask if students have any questions about how to complete the survey. Answer these questions, then have students complete the survey.
8. When students are finished, make sure they place their anonymous surveys in the container you have provided for that purpose.

HOW CONFIDENT ARE YOU?

DO NOT put your name on this survey. Your responses will be kept secret. No one will know how you answered these questions.

DIRECTIONS: This survey asks you about how confident you would feel in different situations. *Try to imagine yourself in the situation.* Mark an X for the answer that fits best.

Example: Your friends are playing a game of football. They know you prefer to play softball, but they urge you to join them anyway. *If you didn't want to play football,* how confident are you that you could refuse?

Completely Confident	Very Confident	Somewhat Confident	Not Very Confident	Not at All Confident
( )	( )	( )	(X)	( )

BEFORE STARTING, PLEASE READ THE FOLLOWING: Some of the situations use the phrase "having sex." This means having sexual intercourse.

Please go on to the next page. ⇒

1. You are at a party where some of your friends are drinking. They want you to join them and are pressuring you to do so. *If you didn't want to join your friends in drinking*, how confident are you that you could refuse?

Completely Confident	Very Confident	Somewhat Confident	Not Very Confident	Not at All Confident
( )	( )	( )	( )	( )

2. Some of your best friends are going to a party, and they want you to come. You think it might be fun. But the last party at this house got out of hand, and a neighbor threatened to call the police. You're afraid the same thing might happen again. *If you didn't want to go to the party*, how confident are you that you could refuse?

Completely Confident	Very Confident	Somewhat Confident	Not Very Confident	Not at All Confident
( )	( )	( )	( )	( )

3. You are going steady with someone, and you like each other very much. Your partner really wants to have sex with you. *If you didn't want to have sex with your steady*, how confident are you that you could refuse?

Completely Confident	Very Confident	Somewhat Confident	Not Very Confident	Not at All Confident
( )	( )	( )	( )	( )

4. You are on a sports team that has a good chance of making it to the championships. Some of the team members decide to inject steroids to make themselves stronger and faster. They want you to join them. *If you didn't want to use steroids*, how confident are you that you could refuse?

Completely Confident	Very Confident	Somewhat Confident	Not Very Confident	Not at All Confident
( )	( )	( )	( )	( )

5. You are in training to run track, and you are trying to cut down on sweets. You have agreed to meet a friend at the ice cream shop, and you are planning to just have a diet drink. Before you get there, your friend orders your favorite milkshake for you, and it is sitting on the counter—waiting. *If you didn't want to drink the milkshake*, how confident are you that you could refuse?

Completely Confident	Very Confident	Somewhat Confident	Not Very Confident	Not at All Confident
( )	( )	( )	( )	( )

Please go on to the next page. ⇒

6. You have recently broken up with your steady. You start to date someone new who knows you had sex with your old steady and wants to have sex with you. You have heard a lot about HIV, and you decide to rethink your sexual habits. *If you didn't want to have sex with your new partner*, how confident are you that you could refuse?

Completely Confident	Very Confident	Somewhat Confident	Not Very Confident	Not at All Confident
( )	( )	( )	( )	( )

7. It's a Sunday afternoon, and you've been putting off your homework all weekend. You've got enough homework to fill the rest of the day. Your best friend calls to invite you to a movie that you've both been wanting to see. *If you didn't want to go with your friend*, how confident are you that you could refuse?

Completely Confident	Very Confident	Somewhat Confident	Not Very Confident	Not at All Confident
( )	( )	( )	( )	( )

8. You are with a bunch of friends. One friend brings equipment to inject drugs. Some of your friends join in and seem to be having a great time. They urge you to join them. You know that sharing needles to inject drugs is an easy way to get infected with HIV. *If you didn't want to join your friends in injecting drugs*, how confident are you that you could refuse?

Completely Confident	Very Confident	Somewhat Confident	Not Very Confident	Not at All Confident
( )	( )	( )	( )	( )

9. You and your friends have just watched your school basketball team win a game in double overtime. It's later than you expected, and you're tired. Several friends suggest that you all go out to get a pizza and celebrate. They pressure you to join them. *If you didn't want to get a pizza with your friends*, how confident are you that you could refuse?

Completely Confident	Very Confident	Somewhat Confident	Not Very Confident	Not at All Confident
( )	( )	( )	( )	( )

10. You are going out with someone, and you've been having sex without condoms. You have heard that using a latex condom is a good way to keep from getting infected with HIV. Your partner doesn't like condoms. *If you didn't want to have sex anymore without a condom*, how confident are you that you could refuse?

Completely Confident	Very Confident	Somewhat Confident	Not Very Confident	Not at All Confident
( )	( )	( )	( )	( )

Your Friends

Assessment Focus: Perceptions of peers' behaviors and values

General Description

This instrument measures students' perceptions of their peers' behaviors and values related to the possibility of being infected with HIV. This instrument contains 10 items calling for students to make estimates about their friends' values and behaviors.

Rationale

It is well known that adolescents' behavior is influenced by what they believe their peers regard as appropriate. This assessment instrument is designed to determine the nature of students' perceptions regarding HIV-related behaviors and values. Respondents are asked to estimate the extent to which their friends engage in certain HIV-risk behaviors or hold values associated with those behaviors. It has been shown that many students overestimate the extent to which their peers engage in HIV-risk behaviors. Such inflated estimates may incline students to engage in "peer-sanctioned" behaviors. Thus, an HIV education program might try to correct these misperceptions of peers' behaviors, as well as alter social norms so that peers' attitudes and behaviors become more positive.

Scoring Procedures

An overall score is not calculated for this inventory. Responses to each of the 10 statements must be interpreted separately. For the group of students assessed, the percentage of responses to the four choices for each item should be determined—for example, the percentage of students who indicate that all their friends "have never had sex," the percentage of students who indicate that most of their friends "have never had sex," and so on. It is possible to collapse response categories such as the "All" and "Most" responses or the "Some" and "None" responses.

Items can be examined for preprogram-to-postprogram shifts that indicate more favorable perceptions of peers' conduct or attitudes. For example, if a schoolwide HIV program were successful, one might see a preprogram-to-postprogram change on Item No. 9, "About how many of your friends believe that teenagers should use a condom if they have sex?"

The questions deal with peers' behaviors and peers' values and are listed by category below:

Peers' Behaviors: 1, 4, 5, 6, 7, 8, 10
Peers' Values: 2, 3, 9

Your Friends

Administration Directions

Note to users of the *Your Friends* survey:

Please carefully follow the administrative directions below. These directions contain information essential to the accurate completion of the survey. Thank you for your cooperation.

Directions:

1. Remind students that they are *not* to write their names on the surveys. Explain that the survey is anonymous.
2. Distribute surveys to students.
3. *Read aloud* to students the directions from the front page of the survey and tell students to follow along as you read.
4. Show students how the "Some" and "Most" responses have been circled in the examples.
5. Inform students that to increase their privacy, you will not be walking around the room while they complete their surveys.
6. Tell students to place their completed surveys in a large manila envelope or box *when everyone has finished.*
7. Ask if students have any questions about how to complete the survey. Answer these questions, then have students complete the survey.
8. When students are finished, make sure they place their anonymous surveys in the container you have provided for that purpose.

YOUR FRIENDS

DO NOT put your name on this survey. Your responses will be kept secret. No one will know how you answered these questions.

DIRECTIONS: This survey asks you to answer some questions about your friends. These people might be boys, girls, or both. Make your responses as accurate as you can. Even if you're not sure, make your *best guess*.

Examples:

	All A	*Most* M	*Some* S	*None* N
1. About how many of your friends smoke at least one cigarette per week?	A	M	[✓ S]	N
2. About how many of your friends think that it's wrong to lie?	A	[✓ M]	S	N

BEFORE STARTING, PLEASE READ THE FOLLOWING: Some of the questions in this survey use the phrase "having sex." This means having sexual intercourse.

Please go on to the next page. ⇒

		All A	*Most* M	*Some* S	*None* N
1.	About how many of your friends use needles to inject drugs or steroids?	A	M	S	N
2.	About how many of your friends believe it is okay for teenagers to have sex before they're married?	A	M	S	N
3.	About how many of your friends believe that it is okay for teenagers to use needles to inject drugs or steroids?	A	M	S	N
4.	About how many of your friends have *never* had sex?	A	M	S	N
5.	About how many of your friends have had sex during the last six months?	A	M	S	N
6.	About how many of your friends have had sex with more than one partner during the last six months?	A	M	S	N
7.	About how many of your friends use a condom when they have sex?	A	M	S	N
8.	About how many of your friends drink alcohol or use drugs before they have sex?	A	M	S	N
9.	About how many of your friends believe that teenagers should use a condom if they have sex?	A	M	S	N
10.	About how many of your friends are trying to change their sexual behaviors because they might get infected with HIV?	A	M	S	N

Your Intentions

Assessment Focus: Intentions regarding HIV-risk behaviors and their precursors

General Description

This instrument measures students' beliefs about how they will behave during the next three months. The instrument contains items asking students to identify how they intend to act in relation to (1) behaviors associated with risk of HIV infection and (2) behaviors precursive to HIV-risk behaviors.

Rationale

More than any other single factor, a person's behavior determines how much risk there is of that person becoming infected with HIV. An important aim of an HIV education program is to influence individuals to move from higher-risk to lower-risk behaviors. Unfortunately, behavioral changes are often slow in coming. Tracking such change over an extended period of time is usually beyond the capabilities of most evaluations of HIV education. Students' *behavioral intentions*, however, can more easily be measured. The measurement of behavioral intent can serve as an approximation to the measurement of actual behavior. To give students a reasonable time frame in which to identify their intentions, each item asks about likely behavior three months into the future.

Scoring Procedures

This instrument can be scored on an item-by-item basis by computing the percentages of students who choose each response. For all three-choice items (that is, items containing an A, B, and C response), Choice C responses represent high-risk behaviors, and Choice B responses represent lower-risk behaviors. Choice A responses represent no-risk behaviors. An effective HIV education program would lead to increased percentages of students moving toward reduced-risk behaviors. For all two-choice items, Choice A is the preferred (lower-risk) response.

The nature of the particular item, of course, must be considered when responses to that item are used for program evaluation. For example, one item asks whether the respondent intends to have sex during the next three months. When interpreting a group's responses to that question at the end of an HIV education program, evaluators should consider the group's preinstruction responses. If a high percentage of the students indicate on other assessment instruments (see the *Your Behavior* survey) that they are abstinent, then responses to the "intention to have sex" item in this inventory should be interpreted accordingly. In other words, if the bulk of the students were abstinent before the program began, then it should not be surprising when there is little shift in item responses.

Your Intentions

Administration Directions

Note to users of the *Your Intentions* survey:

Please carefully follow the administrative directions below. These directions contain information essential to the accurate completion of the survey. Thank you for your cooperation.

Directions:

1. Look at the form letter in the lower right corner of each survey. Make sure that the three forms of the surveys are stacked in the order K, L, M, K, L, M, etc.
2. Remind students that they are *not* to write their names on the surveys. Explain that the survey is anonymous.
3. Distribute surveys to students. Tell students that different persons are receiving different forms of the survey.
4. *Read aloud* to students the directions from the front page of the survey and tell students to follow along as you read.
5. Show students how Choice C is marked in the row of letters for the first example and Choice B is marked in the row of letters for the second example. Explain what the response to each example means. Point out that the response choices are in a different place in each example.
6. *Read aloud* the material in the box at the bottom of the first page; this material explains why the letters on the different forms of the survey are in different places.
7. Inform students that to increase their privacy, you will not be walking around the room while they complete their surveys.
8. Tell students to place their completed surveys in a large manila envelope or box *when everyone has finished.*

9. Ask if students have any questions about how to complete the survey. Answer these questions, then have students complete the survey.

10. When students are finished, make sure they place their anonymous surveys in the container you have provided for that purpose.

YOUR INTENTIONS

DO NOT put your name on this survey. Your responses will be kept secret. No one will know how you answered these questions.

DIRECTIONS: This survey asks you personal questions about your intentions during the next three months. To make sure your answers are private, you will complete this survey in a special way. Read each question and find the answer that is MOST true for you. Then find the letter that goes with that answer in the row of letters between the lines. Put an X through the letter in that row (between the two lines).

Example No. 1: In the next three months, which one of the following do you intend to do?

A. I intend to gain weight.

B. I intend to lose weight.

C. I intend to stay the same weight.

O P Q R S T U V W X Y Z A B [✓ C] D E F G H I J K L M N

Example No. 2: In the next three months, which one of the following do you intend to do?

A. I intend to walk to school.

B. I intend to take a bus to school.

C. I intend to get to school in another way.

S T U V W X Y Z A [✓ B] C D E F G H I J K L M N O P Q R

TO PROTECT YOUR PRIVACY: Your classmates have *different* versions of this survey. *For the same question*, the letters are in a *different* position on your survey and your classmates' surveys. This is done so that no one can easily see your answers. Some of the questions in this survey ask about "having sex." This means having sexual intercourse.

(Form K)

Please go on to the next page. ⇒

1. In the next three months, which one of the following do you intend to do?

A. I don't intend to use alcohol.

B. I intend to use alcohol.

L M N O P Q R S T U V W X Y Z A B C D E F G H I J K

2. In the next three months, which one of the following do you intend to do?

A. I don't intend to use drugs.

B. I intend to use drugs.

R S T U V W X Y Z A B C D E F G H I J K L M N O P Q

3. In the next three months, which one of the following do you intend to do?

A. I don't intend to inject drugs or steroids.

B. I intend to inject drugs or steroids.

T U V W X Y Z A B C D E F G H I J K L M N O P Q R S

4. In the next three months, which one of the following do you intend to do?

A. I don't intend to have sex.

B. I intend to have sex with one person.

C. I intend to have sex with two or more people.

O P Q R S T U V W X Y Z A B C D E F G H I J K L M N

(Form K)

Please go on to the next page. ⇒

5. In the next three months, which one of the following do you intend to do?

A. I don't intend to have sex.

B. I intend to use condoms with my sexual partner(s).

C. I don't intend to use condoms with my sexual partner(s).

P Q R W T U V W X Y Z A B C D E F G H I J K L M N O

6. In the next three months, which one of the following do you intend to do?

A. I intend to be tested for HIV because I think I may be infected.

B. I don't intend to be tested for HIV even though I think I may be infected.

C. I don't intend to be tested for HIV because I am unlikely to be infected.

N O P Q R S T U V W X Y Z A B C D E F G H I J K L M

YOUR INTENTIONS

DO NOT put your name on this survey. Your responses will be kept secret. No one will know how you answered these questions.

DIRECTIONS: This survey asks you personal questions about your intentions during the next three months. To make sure your answers are private, you will complete this survey in a special way. Read each question and find the answer that is MOST true for you. Then find the letter that goes with that answer in the row of letters between the lines. Put an X through the letter in that row (between the two lines).

Example No. 1: In the next three months, which one of the following do you intend to do?

A. I intend to gain weight.

B. I intend to lose weight.

C. I intend to stay the same weight.

O P Q R S T U V W X Y Z A B ~~C~~ D E F G H I J K L M N

Example No. 2: In the next three months, which one of the following do you intend to do?

A. I intend to walk to school.

B. I intend to take a bus to school.

C. I intend to get to school in another way.

S T U V W X Y Z A ~~B~~ C D E F G H I J K L M N O P Q R

TO PROTECT YOUR PRIVACY: Your classmates have *different* versions of this survey. *For the same question*, the letters are in a *different* position on your survey and your classmates' surveys. This is done so that no one can easily see your answers. Some of the questions in this survey ask about "having sex." This means having sexual intercourse.

(Form L)

Please go on to the next page. ⇒

1. In the next three months, which one of the following do you intend to do?
   - A. I don't intend to use alcohol.
   - B. I intend to use alcohol.

O P Q R S T U V W X Y Z A B C D E F G H I J K L M N

2. In the next three months, which one of the following do you intend to do?
   - A. I don't intend to use drugs.
   - B. I intend to use drugs.

U V W X Y Z A B C D E F G H I J K L M N O P Q R S T

3. In the next three months, which one of the following do you intend to do?
   - A. I don't intend to inject drugs or steroids.
   - B. I intend to inject drugs or steroids.

L M N O P Q R S T U V W X Y Z A B C D E F G H I J K

4. In the next three months, which one of the following do you intend to do?
   - A. I don't intend to have sex.
   - B. I intend to have sex with one person.
   - C. I intend to have sex with two or more people.

S T U V W X Y Z A B C D E F G H I J K L M N O P Q R

(Form L)

Please go on to the next page. ⇒

5. In the next three months, which one of the following do you intend to do?

- A. I don't intend to have sex.
- B. I intend to use condoms with my sexual partner(s).
- C. I don't intend to use condoms with my sexual partner(s).

Q R S T U V W X Y Z A B C D E F G H I J K L M N O P

6. In the next three months, which one of the following do you intend to do?

- A. I intend to be tested for HIV because I think I may be infected.
- B. I don't intend to be tested for HIV even though I think I may be infected.
- C. I don't intend to be tested for HIV because I am unlikely to be infected.

H I J K L M N O P Q R S T U V W X Y Z A B C D E F G

YOUR INTENTIONS

DO NOT put your name on this survey. Your responses will be kept secret. No one will know how you answered these questions.

DIRECTIONS: This survey asks you personal questions about your intentions during the next three months. To make sure your answers are private, you will complete this survey in a special way. Read each question and find the answer that is MOST true for you. Then find the letter that goes with that answer in the row of letters between the lines. Put an X through the letter in that row (between the two lines).

Example No. 1: In the next three months, which one of the following do you intend to do?

A. I intend to gain weight.

B. I intend to lose weight.

C. I intend to stay the same weight.

O P Q R S T U V W X Y Z A B C D E F G H I J K L M N

Example No. 2: In the next three months, which one of the following do you intend to do?

A. I intend to walk to school.

B. I intend to take a bus to school.

C. I intend to get to school in another way.

S T U V W X Y Z A B C D E F G H I J K L M N O P Q R

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(Form M)

Please go on to the next page. ⇒

1. In the next three months, which one of the following do you intend to do?
   - A. I don't intend to use alcohol.
   - B. I intend to use alcohol.

R S T U V W X Y Z A B C D E F G H I J K L M N O P Q

2. In the next three months, which one of the following do you intend to do?
   - A. I don't intend to use drugs.
   - B. I intend to use drugs.

M N O P Q R S T U V W X Y Z A B C D E F G H I J K L

3. In the next three months, which one of the following do you intend to do?
   - A. I don't intend to inject drugs or steroids.
   - B. I intend to inject drugs or steroids.

P Q R S T U V W X Y Z A B C D E F G H I J K L M N O

4. In the next three months, which one of the following do you intend to do?
   - A. I don't intend to have sex.
   - B. I intend to have sex with one person.
   - C. I intend to have sex with two or more people.

X Y Z A B C D E F G H I J K L M N O P Q R S T U V W

(Form M)

Please go on to the next page. ⇒

5. In the next three months, which one of the following do you intend to do?

   A. I don't intend to have sex.
   B. I intend to use condoms with my sexual partner(s).
   C. I don't intend to use condoms with my sexual partner(s).

F G H I J K L M N O P Q R S T U V W X Y Z A B C D E

6. In the next three months, which one of the following do you intend to do?

   A. I intend to be tested for HIV because I think I may be infected.
   B. I don't intend to be tested for HIV even though I think I may be infected.
   C. I don't intend to be tested for HIV because I am unlikely to be infected.

J K L M N O P Q R S T U V W X Y Z A B C D E F G H I

Your Behavior

Assessment Focus: HIV-risk behaviors

General Description

This instrument is designed to measure HIV-risk behaviors among students. Students supply their answers to this survey's questions by using a distinctive response scheme that reduces the likelihood a student's responses can be easily seen by other students.

Rationale

Central to the issue of HIV education is the fact that certain behaviors increase a person's chances of becoming infected with HIV and that these behaviors can be avoided. If an adolescent discontinues or never initiates certain high-risk behaviors (e.g., unsafe sexual practices or intravenous drug use), the threat of infection with HIV will be reduced.

Scoring Procedures

To score this instrument, an item-by-item analysis of students' responses is recommended. For each item, calculate the percentage of persons who respond to each answer choice. Program effectiveness will be indicated by changes in students' preprogram-to-postprogram responses in the direction of reduced risk behaviors.

Your Behavior

Administration Directions

Note to users of the *Your Behavior* survey:

Please carefully follow the administrative directions below. These directions contain information essential to the accurate completion of the survey. Thank you for your cooperation.

Directions:

1. Look at the form letter in the lower right corner of each survey. Make sure that the three forms of the surveys are stacked in the order K,L,M,K,L,M, etc.
2. Remind students that they are *not* to write their names on the surveys. Explain that the survey is anonymous.
3. Distribute surveys to students. Tell students that different persons are receiving different forms of the surveys.
4. *Read aloud* to students the directions from the front page of the survey and tell students to follow along as you read.
5. Show students how Choice C is marked in the row of letters for the first example and Choice B is marked in the row of letters for the second example. Explain what the response to each example means. Point out that the response choices are in a different place in each example.
6. *Read aloud* the material in the box at the bottom on the first page; this material explains why the letters on the different forms of the survey are in different places.
7. Inform students that to increase their privacy, you will not be walking around the room while they complete their surveys.
8. Tell students to place their completed surveys in a large manila envelope or box *when everyone has finished.*

9. Ask if students have any questions about how to complete the survey. Answer these questions, then have students complete the survey.

10. When students are finished, make sure they place their anonymous surveys in the container you have provided for that purpose.

YOUR BEHAVIOR

DO NOT put your name on this survey. Your answers will be kept secret. No one will know how you answered these questions.

DIRECTIONS: This survey asks you personal questions. To make sure your answers are secret, you will complete this survey in a special way. Read each question and find the answer that is MOST true for you. Then find the letter that goes with that answer in the row of letters between the lines. Put an X through the letter in that row (between the two lines).

Example No. 1: Which one of these statements about the *past 30 days* is MOST true for you?

A. I did not smoke any cigarettes.

B. I smoked less than 10 cigarettes.

C. I smoked 10 or more cigarettes.

O P Q R S T U V W X Y Z A B ~~C~~ D E F G H I J K L M N

Example No. 2: Which one of these statements about the *last time* you ate at a fast-food restaurant is MOST true for you?

A. I never eat at fast-food restaurants.

B. I went by myself.

C. I went with family members.

D. I went with friends.

S T U V W X Y Z A ~~B~~ C D E F G H I J K L M N O P Q R

TO PROTECT YOUR PRIVACY: Your classmates have *different* versions of this survey. *For the same question*, the letters are in a *different* position on your paper and on your classmates' papers. This is done so that no one can easily see your answers. Some of the questions in this survey ask about "having sex." This means having sexual intercourse.

(Form K)

Please go on to the next page. ⇒

1. Which one of these statements about the *past 30 days* is MOST true for you?
    - A. I wasn't in a situation where friends were using alcohol or drugs.
    - B. I was in situations where friends were using alcohol or drugs, but I never used any.
    - C. I was in situations where friends were using alcohol or drugs, and I used some, too.

U V W X Y Z A B C D E F G H I J K L M N O P Q R S T

2. Which one of these statements is MOST true for you?
    - A. During my life, I have never had sex.
    - B. During my life, I have had sex with one person.
    - C. During my life, I have had sex with two people.
    - D. During my life, I have had sex with three people.
    - E. During my life, I have had sex with four or more people.

O P Q R S T U V W X Y Z A B C D E F G H I J K L M N

3. Which one of these statements about the *past 30 days* is MOST true for you?
    - A. I did not have sex.
    - B. I had sex with one person.
    - C. I had sex with two people.
    - D. I had sex with three people.
    - E. I had sex with four or more people.

S T U V W X Y Z A B C D E F G H I J K L M N O P Q R

4. Which one of these statements about the *last time* you had sex is MOST true for you?
    - A. I have never had sex.
    - B. My partner or I used a condom.
    - C. My partner or I didn't use a condom.

V W X Y Z A B C D E F G H I J K L M N O P Q R S T U

(Form K)

Please go on to the next page. ⇒

5. Which one of these statements is MOST true for you?

A. During my lifetime, I have never injected drugs.

B. During my lifetime, I have injected drugs.

M N O P Q R S T U V W X Y Z A B C D E F G H I J K L

6. Which one of these statements about the *past 30 days* is MOST true for you?

A. I did not inject drugs or steroids.

B. I did inject drugs or steroids.

N O P Q R S T U V W X Y Z A B C D E F G H I J K L M

7. Which one of these statements about the *past 30 days* is MOST true for you?

A. I was tested for HIV.

B. I was not tested for HIV even though I think I may be infected.

C. I was not tested for HIV because I am unlikely to be infected.

T U V W X Y Z A B C D E F G H I J K L M N O P Q R S

YOUR BEHAVIOR

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DIRECTIONS: This survey asks you personal questions. To make sure your answers are secret, you will complete this survey in a special way. Read each question and find the answer that is MOST true for you. Then find the letter that goes with that answer in the row of letters between the lines. Put an X through the letter in that row (between the two lines).

Example No. 1: Which one of these statements about the *past 30 days* is MOST true for you?

A. I did not smoke any cigarettes.
B. I smoked less than 10 cigarettes.
C. I smoked 10 or more cigarettes.

O P Q R S T U V W X Y Z A B C D E F G H I J K L M N

Example No. 2: Which one of these statements about the *last time* you ate at a fast-food restaurant is MOST true for you?

A. I never eat at fast-food restaurants.
B. I went by myself.
C. I went with family members.
D. I went with friends.

S T U V W X Y Z A B C D E F G H I J K L M N O P Q R

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(Form L)

Please go on to the next page. ⇒

1. Which one of these statements about the *past 30 days* is MOST true for you?

   A. I wasn't in a situation where friends were using alcohol or drugs.

   B. I was in situations where friends were using alcohol or drugs, but I never used any.

   C. I was in situations where friends were using alcohol or drugs, and I used them, too.

Q R S T U V W X Y Z A B C D E F G H I J K L M N O P

2. Which one of these statements is MOST true for you?

   A. During my life, I have never had sex.

   B. During my life, I have had sex with one person.

   C. During my life, I have had sex with two people.

   D. During my life, I have had sex with three people.

   E. During my life, I have had sex with four or more people.

K L M N O P Q R S T U V W X Y Z A B C D E F G H I J

3. Which one of these statements about the *past 30 days* is MOST true for you?

   A. I did not have sex.

   B. I had sex with one person.

   C. I had sex with two people.

   D. I had sex with three people.

   E. I had sex with four or more people.

M N O P Q R S T U V W X Y Z A B C D E F G H I J K L

4. Which one of these statements about the *last time* you had sex is MOST true for you?

   A. I have never had sex.

   B. My partner or I used a condom.

   C. My partner or I didn't use a condom.

S T U V W X Y Z A B C D E F G H I J K L M N O P Q R

Please go on to the next page. ⇒

5. Which one of these statements is MOST true for you?

A. During my lifetime, I have never injected drugs.

B. During my lifetime, I have injected drugs.

D E F G H I J K L M N O P Q R S T U V W X Y Z A B C

6. Which one of these statements about the *past 30 days* is MOST true for you?

A. I did not inject drugs or steroids.

B. I did inject drugs or steroids.

T U V W X Y Z A B C D E F G H I J K L M N O P Q R S

7. Which one of these statements about the *past 30 days* is MOST true for you?

A. I was tested for HIV.

B. I was not tested for HIV even though I think I may be infected.

C. I was not tested for HIV because I am unlikely to be infected.

F G H I J K L M N O P Q R S T U V W X Y Z A B C D E

YOUR BEHAVIOR

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C. I smoked 10 or more cigarettes.

O P Q R S T U V W X Y Z A B [✓ C] D E F G H I J K L M N

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A. I never eat at fast-food restaurants.

B. I went by myself.

C. I went with family members.

D. I went with friends.

S T U V W X Y Z A [✓ B] C D E F G H I J K L M N O P Q R

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(Form M)

Please go on to the next page. ⇒

1. Which one of these statements about the *past 30 days* is MOST true for you?

A. I wasn't in a situation where friends were using alcohol or drugs.

B. I was in situations where friends were using alcohol or drugs, but I never used any.

C. I was in situations where friends were using alcohol or drugs, and I used some, too.

K L M N O P Q R S T U V W X Y Z A B C D E F G H I J

2. Which one of these statements is MOST true for you?

A. During my life, I have never had sex.

B. During my life, I have had sex with one person.

C. During my life, I have had sex with two people.

D. During my life, I have had sex with three people.

E. During my life, I have had sex with four or more people.

G H I J K L M N O P Q R S T U V W X Y Z A B C D E F

3. Which one of these statements about the *past 30 days* is MOST true for you?

A. I did not have sex.

B. I had sex with one person.

C. I had sex with two people.

D. I had sex with three people.

E. I had sex with four or more people.

O P Q R S T U V W X Y Z A B C D E F G H I J K L M N

4. Which one of these statements about the *last time* you had sex is MOST true for you?

A. I have never had sex.

B. My partner or I used a condom.

C. My partner or I didn't use a condom.

J K L M N O P Q R S T U V W X Y Z A B C D E F G H I

(Form M)

Please go on to the next page. ⇒

5. Which one of these statements is MOST true for you?

A. During my lifetime, I have never injected drugs.

B. During my lifetime, I have injected drugs.

T U V W X Y Z A B C D E F G H I J K L M N O P Q R S

6. Which one of these statements about the *past 30 days* is MOST true for you?

A. I did not inject drugs or steroids.

B. I did inject drugs or steroids.

H I J K L M N O P Q R S T U V W X Y Z A B C D E F G

7. Which one of these statements about the *past 30 days* is MOST true for you?

A. I was tested for HIV.

B. I was not tested for HIV even though I think I may be infected.

C. I was not tested for HIV because I am unlikely to be infected.

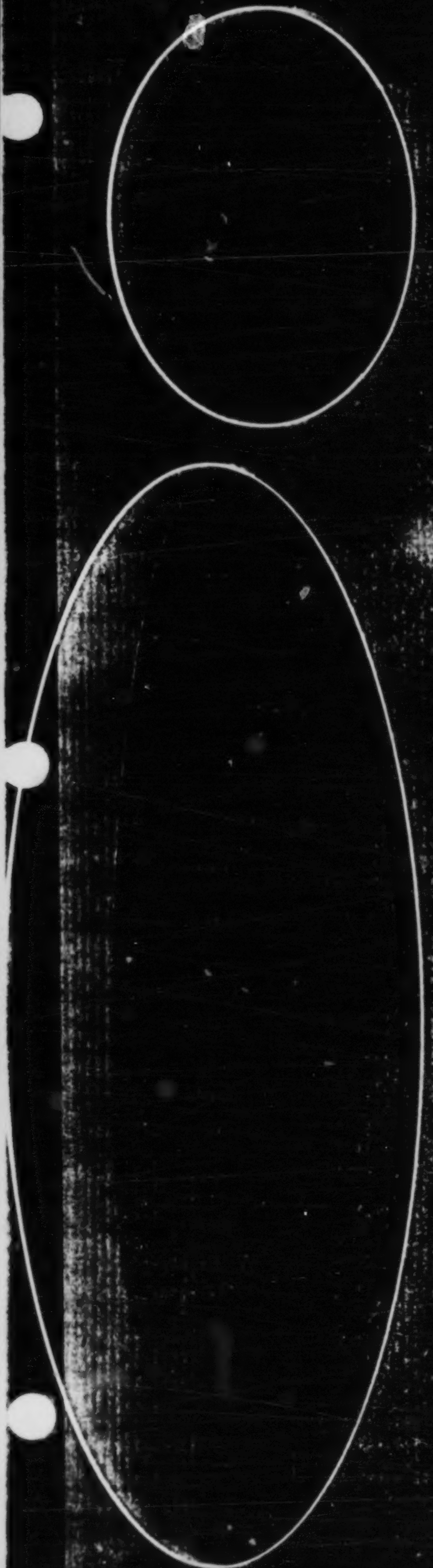
O P Q R S T U V W X Y Z A B C D E F G H I J K L M N

HANDBOOK OVERVIEW

This booklet is part of a series of eight booklets included in the *Handbook for Evaluating HIV Education*. The handbook contains evaluation designs and measurement tools necessary to collect data on the basic program components of policy development, curriculum design, teacher training, and student outcomes. The eight booklets are listed below.

1. Evaluating HIV Education Programs
2. Developing and Revising HIV Policies
3. Appraising an HIV Curriculum
4. Evaluating HIV Staff Development Programs
5. Assessment Instruments for Measuring Student Outcomes: Grades 5-7
6. **Assessment Instruments for Measuring Student Outcomes: Grades 7-12**
7. Choosing and Using an External Evaluator
8. Reporting Results of HIV Education Evaluations

For further information on the use of these booklets, please contact your state HIV coordinator or your CDC project officer.



Choosing
and
Using an
External
Evaluator

BOOKLET 7

DIVISION OF ADOLESCENT AND SCHOOL HEALTH
NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION
AND HEALTH PROMOTION
CENTERS FOR DISEASE CONTROL

CHOOSING AND USING AN EXTERNAL EVALUATOR

Donald C. Iverson

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TABLE OF CONTENTS

Page

INTRODUCTION 1

GUIDELINES

- Guideline 1: Form an evaluation committee. 1
- Guideline 2: Define the evaluation. 2
- Guideline 3: Solicit candidates. 2
- Guideline 4: Interview and select the evaluator. 3
- Guideline 5: Write and negotiate the contract. 7
- Guideline 6: Interact closely with the evaluator. 7
- Guideline 7: Prepare the final report and release of results. 8

CONCLUSION 8

APPENDICES

- A: Sample Job Description 11
- B: Candidate Rating Form 13
- C: Sample Contract 17

Introduction

An important aspect of every HIV education program is program evaluation. Evaluation of HIV education is especially important since so little is known about these programs. Only through well-designed, systematic evaluations can the essential components of successful HIV programs be identified. Further, evaluation results will provide educators with information regarding the expected effects of well-designed and adequately implemented HIV education programs.

Objectivity is vital to an effective evaluation, and an external evaluator is often the surest method of attaining that. An external evaluator, however, should not be hurriedly chosen, because program personnel can easily become dissatisfied with an inappropriate evaluation approach and can then question the usefulness of its results.

Well-planned and well-conducted evaluations are invaluable in determining how an HIV education program can be improved. Such evaluations can also assist program personnel in making judgments about program effectiveness with a target population. The following seven guidelines can direct you in selecting and interacting with an appropriate external evaluator.

Guideline 1: Form an evaluation committee.

Form an evaluation committee.

An evaluation committee should oversee the entire evaluation process, from initial planning, through implementation, through final report. This committee should be made up of persons representing the various aspects of the HIV education program, including teachers who will deliver the curriculum or train other teachers to deliver it. The committee's size will depend on the size of your program. A large program will support an evaluation committee of five to seven persons, chaired by the project director. Smaller programs, of course, may involve no more than three people in all—some, perhaps only a single staffer. In such cases, the evaluation committee might need to include the entire program staff.

The evaluation committee will have primary responsibility for all aspects of the evaluation and will receive regular reports from the external evaluator. Committee members must be actively involved in the evaluation process to increase their understanding of it and to allow them to make effective use of evaluation results.

Guideline 2: Define the evaluation.

Define the evaluation.

The evaluation committee must have a clear understanding of what it wants the evaluation to accomplish. In particular, the committee must identify the decisions intended to be the focus of the evaluation. Once these decisions have been identified and clarified in writing, the committee should identify specific tasks for which the external evaluator will be responsible. These tasks should relate directly to the decisions to be addressed by the evaluation and might include development of the evaluation plan, development of evaluation instruments, selection of the sampling procedures and drawing of the evaluation sample, collection of evaluation data, analysis of evaluation data, composition of the evaluation report, and assistance in presenting evaluation results.

Once these tasks have been determined, the committee must compose a job description including these and any other requirements for the position. An overall description of your HIV education project and an estimate of the evaluation funds available should also be included in this document. (See Appendix A for a sample job description.)

The job description should end with detailed instructions of how potential candidates are to apply for the position, identifying all information and documentation they must provide to the committee. At a minimum, the committee will want to review a copy of at least one evaluation report previously written by the applicant and at least two references from individuals or organizations for which evaluation services have been rendered.

Guideline 3: Solicit candidates.

Solicit candidates.

Once the job description has been completed, it should be distributed to local colleges and universities and to professional organizations such as the American Educational Research Association and the National Council on Measurement in Education. It should also be advertised at least once in the local newspaper. The evaluation office and the personnel office of the state education agency can often provide assistance in identifying or soliciting viable applicants. Viable candidates with academic credentials in program evaluation can usually be found in college or university departments of educational research and statistics. Specialized academic centers, such as centers for health services research or educational research, are another potential source of candidates. You might also use

223

your own existing network of contacts to identify persons who have conducted program evaluations for other organizations in your community.

Send copies of the job description to all identified candidates. When someone is identified as a good program evaluator, a telephone call or letter to recruit that person is appropriate. If an external evaluator is selected who resides outside your immediate geographical area, make sure the evaluator will be able to participate in regular evaluation committee meetings.

Guideline 4: Interview and select the evaluator.

Select the evaluator.

Although the evaluation committee will review a number of applicants for the position, it should narrow the pool down to five or fewer candidates for formal interviews. The committee will want to explore a number of issues during these interviews. The following questions—to be asked of the candidate or discussed among committee members—may be helpful.

Does the candidate understand the difference between research and evaluation?

The primary purpose of research is to develop a new knowledge base or expand on an existing one. On the other hand, the primary purpose of program evaluation is to provide information related to specific program improvement or program continuation decisions. It is possible, of course, for program evaluation efforts to expand on an existing knowledge base while simultaneously providing program personnel with the information they need. However, external evaluators are sometimes more interested in conducting research peripheral to the evaluation needs of the program—in part, because of their desire to publish in research journals. Such instances will usually lead to ineffective evaluation results. To prevent such a situation, have the candidate describe the difference between research and evaluation approaches. If a candidate does not understand or appreciate this difference, he or she will likely lean toward research during your evaluation because most graduate programs emphasize the acquisition of research rather than program evaluation skills.

Does the candidate understand your program?

Have the candidate describe his or her understanding of your program's intent (as reflected in the information you provide to applicants) and how its goals are to be attained. If the candidate misunderstands program goals or operational strategies, make corrections at this time to give the candidate a fair opportunity to respond to subsequent questions. It is important that you feel comfortable about the candidate's understanding of your program's goals and strategies.

What would the candidate's general approach be to your evaluation?

Have the candidate describe the general approach he or she intends to take for the evaluation. Pay attention to questions and issues the candidate believes should be the focus of the evaluation, the type of data to be collected to address those questions and issues, the method of data collection, and the presentation of the evaluation's results. If the discussion becomes very technical and a candidate is unable to present information that you can understand, it is unlikely that this candidate will meet your needs. A candidate unable to communicate effectively at this time will probably not overcome the problem during the evaluation. Effective communication is a key for success, and the interview gives committee members a good idea of how effectively a candidate can communicate.

Does the candidate believe your evaluation can be conducted for the available monies?

Candidates must indicate that their proposed evaluation approach can be carried out for the monies you indicated would be available. You may find a proposed evaluation plan to be excellent but unattainable under your anticipated budget.

All candidates who pass the initial screening process should be asked to produce a detailed budget for the evaluation. A detailed budget is useful for identifying the aspects of the evaluation that are being emphasized, as well as for providing the committee with a way of monitoring the overall evaluation effort.

What is the candidate's reaction to supervision by the evaluation committee?

The evaluator should report to the evaluation committee to assist the committee's supervision of the evaluation. It is reasonable to assume that a candidate unwilling to work under such conditions is not appropriate for the position.

Experienced evaluators might offer suggestions to help your committee's proposed project management operate more efficiently and effectively.

What is the candidate's prior evaluation experience?

Experience is an important factor to consider. A candidate probably will not have performed exactly the same evaluation that you require, but many similarities between previous programs and your own can be found. The candidate's prior experience will be your main opportunity to discover and weigh that person's strengths and weaknesses.

How useful are the candidate's previous evaluation reports?

Look for evaluation reports for which the candidate served as lead author. Assess the reports for their clarity, organization, readability, and potential usefulness for decision makers. Pay particular attention to how well they would help a program improve. Candidates providing technical, poorly written, disorganized, difficult-to-understand, or lengthy evaluation reports will likely compose similar reports for your evaluation. Evaluators with poor writing skills are all too common, and a poorly written report can ruin the best evaluation study.

Does the candidate have good references?

Candidates should be asked to provide the names of at least two persons or organizations for whom they have previously conducted evaluation projects. These references should be contacted for objective views of the candidates. Here are some questions you could ask the references.

- Did the evaluation approach used by the evaluator address the needs and desires of your organization?

- Was the evaluation conducted in a timely fashion?
- Was the evaluation conducted within your budget?
- Was the evaluation report useful to you?
- Would you hire the evaluator to conduct another evaluation for you?

Will the candidate's existing professional commitments interfere with the planned evaluation?

Good program evaluators are usually in demand. A candidate who is engaged in several projects, however, may be unable to devote sufficient time to your program evaluation. Ask the candidate to describe current and expected professional commitments. If the commitments seem excessive, ask how the candidate plans to conduct your program evaluation along with these other tasks. If the candidate indicates that other persons will be used to assist with the evaluation, determine which tasks will be performed by whom. Also determine if these other persons are capable of performing the tasks assigned to them. Using a team of trained and experienced persons to perform an evaluation is common, but the committee must satisfy itself that the team leader (i.e., the candidate) will be involved in all tasks that the committee believes require this person's direct involvement.

What is your general reaction to the candidate?

During interviews, be alert to the candidate's ability to communicate in a straightforward manner, and be alert to your own expectations of how effectively you and your colleagues can work with this person. A clash of working styles can certainly be a problem, and the chemistry between a candidate and committee members is not always right. Negative subjective reactions should be viewed as a serious problem that may not be easily resolved.

What is your overall rating of the candidate?

Following the interview process, committee members should individually rate the candidates on all of the issues previously described. Candidates might be rated on a five-point Likert-type scale, ranging from "Definitely hire as our evaluator" to "Definitely do not hire as our evaluator." "No opinion" should be the midpoint. (See Appendix B for a sample form for rating candidates.) After combining committee members' individual scores, the candidates should be ranked so that the position can be offered to the candidate most acceptable to the majority of committee members.

Guideline 5: Write and negotiate the contract.

Write the contract.

The desired relationship between the evaluation committee and the external evaluator is one of partnership and should be reflected as such in the contract. The contract should state, in a single paragraph if possible, the evaluator's general responsibilities. Also include in this paragraph a brief statement detailing your intended decision-making process and the authority of the evaluation committee. In another paragraph, list the contract deliverables and provide a timetable for them. Many evaluation contracts also specify who owns the data gathered during the evaluation as well as who has the right to publish the results of the evaluation study. Finally, indicate how the evaluator will bill for services rendered and a schedule of payment. Between 20 and 30 percent of the evaluator's fee should be withheld until the acceptance of the final report by the committee.

The contract should also detail the evaluation committee's responsibilities to provide the external evaluator with timely and appropriate guidance, to review and approve evaluation instruments and documents in a timely and constructive manner, and to assist the evaluator in solving problems that arise during the evaluation. (See Appendix C for a sample contract.)

Guideline 6: Interact closely with the evaluator.

Interact with the evaluator.

At the first meeting with the evaluator, the evaluation committee should again describe the overall project and express its expectations of how the evaluation should be conducted. Following this general discussion, the evaluator and the committee should schedule, and make agendas for, subsequent meetings to keep the evaluation moving in a timely and efficient manner. Later meetings should encompass a review of the sample selection process and a discussion of the data-collection plan. The more specific the agenda you make for subsequent meetings, the more likely that the evaluation will meet the needs of the program and be completed in a timely manner. Be sure to keep minutes of the committee meetings. The minutes need not be detailed but should record decisions made about the evaluation effort.

The committee's involvement in the evaluation process, however, should not be limited to periodic meetings with the evaluator. The committee, in part or in whole, should continually monitor the evaluator and the evaluation. A committee only intermittently involved in the evaluation process might not be aware that the evaluation is going in an inappropriate direction before considerable time, money, and effort have been wasted.

Guideline 7: Prepare the final report and release of results.

Prepare the final evaluation report.

As your HIV education evaluation nears completion, the committee and the evaluator should agree on a format for the evaluation report. The evaluation report should address evaluation questions directly and briefly and should be understandable to the target audience. Any report, of course, must provide useful and direct guidance for program decision makers. The committee and the evaluator should also agree at this time on the evaluator's role in the release of the evaluation's results. The committee may request that the evaluator be available to meet with decision makers, conduct interviews with news media, and make public presentations of the results.

The evaluator customarily submits a preliminary draft of the final report to committee members for review and comment. If the changes suggested by the committee are significant and would have the effect of changing the findings, recommendations, or overall focus of the report, they should be discussed at a meeting between the committee and the evaluator. If the evaluator does not believe that the suggested changes are consistent with the data, the evaluator has the right to be disassociated from the report. In such an instance, the evaluator may make the requested changes and assign authorship of the report to the committee. Such situations should be avoided, however, as they usually place the integrity and public acceptance of the report in jeopardy.

Conclusion

Most evaluations of HIV education programs are undertaken to help decision makers improve the program. The relationship between the evaluation committee and the external evaluator must thus be viewed as a functional partnership. An effective functional partnership is founded on agreement over the objectives of the evaluation, an understanding of the responsibilities and authority of each partner, and mutual respect for the contributions that each partner provides to the evaluation. Your committee must have ultimate responsibility for the program's evaluation, and the evaluator, as a partner, should function as an advisor and staff person to you. Selecting an appropriate evaluator will largely depend upon your committee's specificity in identifying the evaluation tasks to be performed, the effort you put into the selection process, and the extent and quality of your interaction with the evaluator in the development and implementation of the evaluation. If the steps identified in this booklet are followed, the evaluation process should be enjoyable and productive for both the evaluation committee and the external evaluator.

APPENDIX A

Sample Job Description

Program Evaluator

The HIV Prevention Program of XYZ state wishes to contract someone to design and conduct an evaluation of a school-based HIV prevention program. (A description of the program, taken from the grant application, is attached.) The evaluation, which is to be conducted during the 1991-1992 school year, is intended to help planning personnel improve the program.

Interested candidates should submit a letter of intent in which their prior evaluation experiences are outlined, a current resumé, a copy of an evaluation report written by the candidate, and the names of two persons for whom program evaluations have been conducted. The above information should be sent to: Ms. Jane Zee, XYZ state. Applications postmarked by 4-15-91 will be accepted.

Candidates who are invited for an interview should be prepared to discuss the evaluation approach they would propose, based on the information provided in the attached program description. Candidates should assume that approximately $40,000 is available for the evaluation, including personnel costs.

APPENDIX B

Candidate Rating Form

Candidate Name: ______________________________________

1. **Distinction between research and evaluation**

Clearly understands the distinction between evaluation and research	No opinion	Has no understanding of the distinction between evaluation and research

2. **Understanding of the program**

Has excellent understanding of the program	No opinion	Has no understanding of the program

3. **Evaluation approach**

Understandable: can clearly explain how evaluation approach addresses needs of program	No opinion	Not understandable: cannot clearly explain how evaluation approach addresses needs of program

4. **Evaluation costs**

Evaluation is very likely to be conducted with available resources	No opinion	Evaluation can't be conducted with available resources

5. **Reaction to management structure**

Supports management structure	No opinion	Wants sole authority

6. Prior evaluation experience

Has done evaluations similar to this one	No opinion	Has no experience with evaluations such as this one

7. Usefulness of previous evaluation reports

Evaluation reports are understandable and useful	No opinion	Evaluation reports are not understandable or useful

8. References

Excellent	No opinion	Poor

9. Professional commitments

Commitments will not interfere with evaluation	No opinion	Commitments will interfere with evaluation

10. General reaction (manner, personality)

Very positive	No opinion	Very negative

11. Overall rating

Definitely hire as our evaluator	No opinion	Definitely do not hire as our evaluator

APPENDIX C

Sample Contract[*]

The evaluator, ________________________________, is responsible for designing and conducting an evaluation of the HIV education program of the XYZ State Department of Education. The evaluator is responsible for preparing the evaluation plan, developing the evaluation instruments, identifying the program participants who will complete the evaluation instruments, administering the evaluation instruments to the selected participants, entering the data onto a computer tape or disc, conducting the appropriate statistical analyses, writing the evaluation report, and presenting the evaluation's results to designated parties. The evaluator reports to the HIV Education Director, Ms. Jane Zee, but an Evaluation Committee chaired by Ms. Zee has oversight responsibility for the evaluation. The overall evaluation plan as well as the evaluation instruments, sampling plan, data-collection plan, data-analysis plan, and final report must be submitted to, and approved by, the Evaluation Committee. The evaluator serves as an advisor to the Evaluation Committee and is expected to attend all meetings of the Committee, unless informed otherwise.

The Evaluation Committee is responsible for making timely decisions regarding the overall evaluation plan and its components. If the Committee recommends changes in the plan, the suggested changes will be specific and feasible within the scope of this contract. If the evaluator disputes the feasibility of the changes, Ms. Zee will be the final arbiter. If the Evaluation Committee reverses one of its decisions, and the changes require additional work on the part of the evaluator, the contract may be modified as agreed to by Ms. Zee and within the regulations of XYZ state. The Evaluation Committee will also be responsible for assisting the evaluator in securing permission for collecting the evaluation data, as well as assisting the evaluator in resolving political or logistical barriers to conducting the evaluation. The Evaluation Committee will assist the evaluator in developing a model outline for the evaluation report. Finally, the Evaluation Committee will identify the person(s) to whom a presentation of the evaluation's results will be made.

The evaluation contract will be in effect from July 1, 1991, through June 30, 1992. The evaluator will deliver the following products at the times specified below.

1.	General evaluation plan	7-15-91
2.	Evaluation instruments	8-31-91
3.	Sampling plan and sampling frame	9-30-91
4.	Data-collection plan	9-30-91
5.	Data-analysis plan	9-30-91
6.	Collection of evaluation data	3-15-92
7.	Evaluation report, including data tape or disc	5-31-92
8.	Presentation (limit of 2) of evaluation results	6-30-92

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[*] This sample contract illustrates content typically included in such documents and is *not* intended for use as a legal contract. Before issuing your own contract, be sure to review it with your own legal counsel.

A deliverable will not be considered satisfactorily completed until it is approved/accepted by the Evaluation Committee. If a deliverable is not approved/accepted by the Evaluation Committee, specific reasons for its disapproval/rejection must be provided to the evaluator within two weeks of the deliverable's receipt.

The payment schedule for the contract is as follows: 10% after deliverable #1; 20% after deliverable #2; 10% after deliverables #3-5; 30% after deliverable #6; 20% after deliverable #7; and 10% after deliverable #8.

Accepted by:

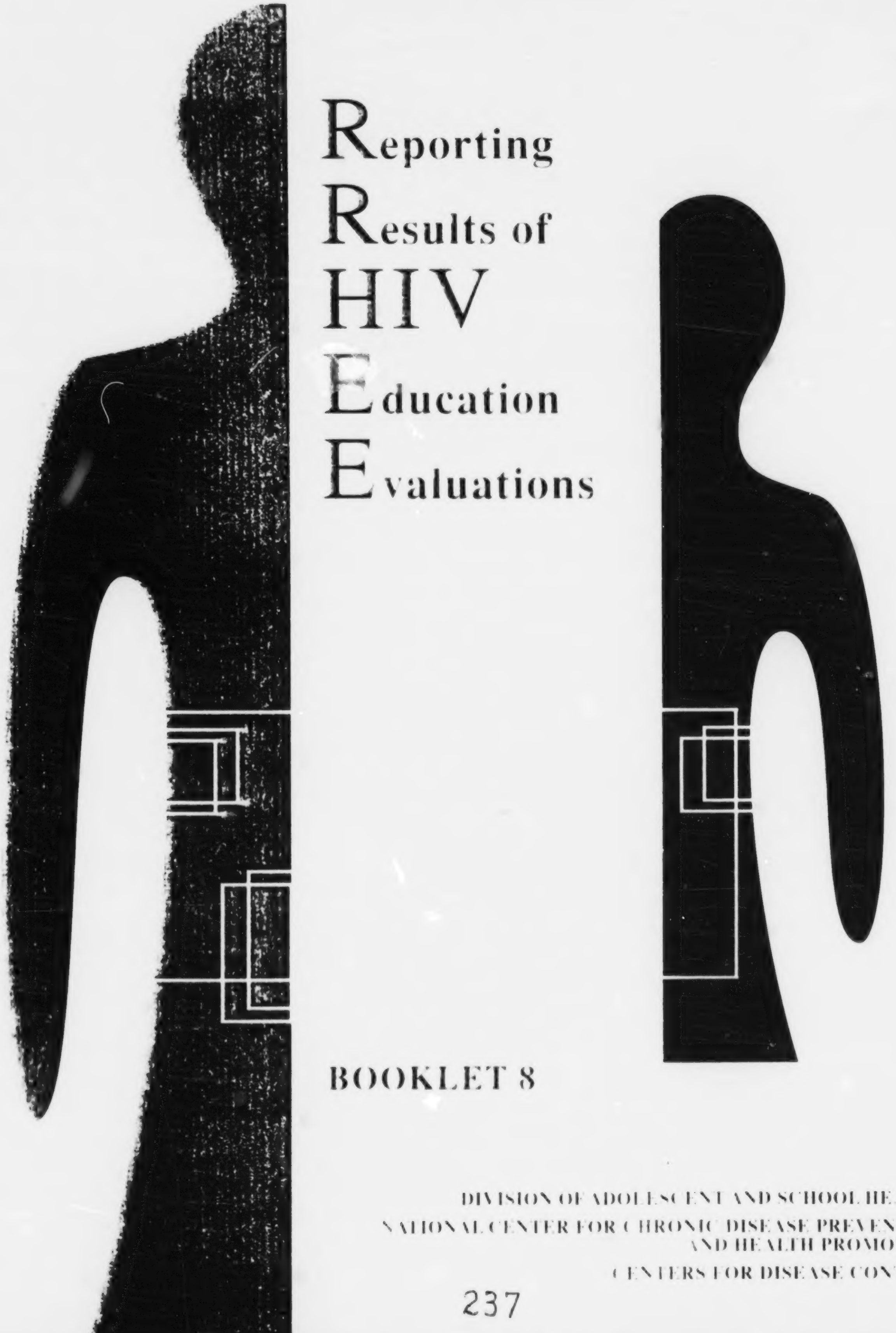
______________________________	______________________________
	Evaluator
______________________________	
State XYZ Officials	
______________________________	______________________________
Date	Date

HANDBOOK OVERVIEW

This booklet is part of a series of eight booklets included in the *Handbook for Evaluating HIV Education*. The handbook contains evaluation designs and measurement tools necessary to collect data on the basic program components of policy development, curriculum design, teacher training, and student outcomes. The eight booklets are listed below.

1. Evaluating HIV Education Programs
2. Developing and Revising HIV Policies
3. Appraising an HIV Curriculum
4. Evaluating HIV Staff Development Programs
5. Assessment Instruments for Measuring Student Outcomes: Grades 5-7
6. Assessment Instruments for Measuring Student Outcomes: Grades 7-12
7. Choosing and Using an External Evaluator
8. Reporting Results of HIV Education Evaluations

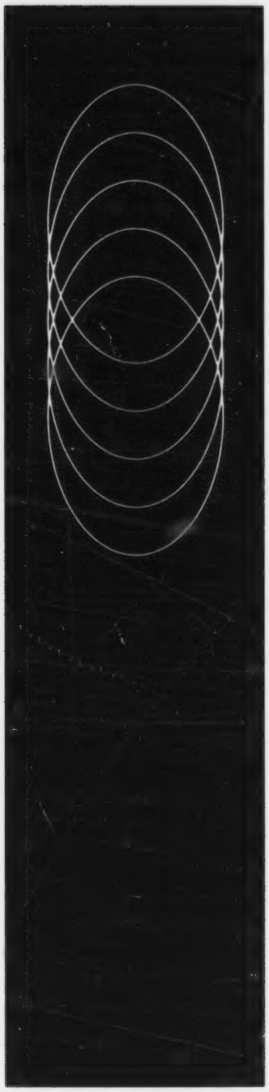
For further information on the use of these booklets, please contact your state HIV coordinator or your CDC project officer.



Reporting
Results of
HIV
Education
Evaluations

BOOKLET 8

DIVISION OF ADOLESCENT AND SCHOOL HEALTH
NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION
AND HEALTH PROMOTION
CENTERS FOR DISEASE CONTROL



Reporting Results of HIV Education Evaluations

W. James Popham

This booklet was prepared by IOX Assessment Associates under
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Centers for Disease Control.

TABLE OF CONTENTS

Page

INTRODUCTION 1

FIVE REPORT PREPARATION GUIDELINES 1

- Guideline 1: Evaluation reports should be decision focused. 1
- Guideline 2: Evaluation reports should be as brief as possible. 2
- Guideline 3: At least two levels of detail should be provided in all evaluation reports. 3
- Guideline 4: Evaluation reports should be as readable as possible. 4
- Guideline 5: Offer to provide an oral report about the study. 5

CONCLUSION 5

THREE SAMPLE EVALUATION REPORTS 7

- *Evaluating a District HIV/AIDS Education Program* 9
- *Evaluating a State HIV Staff Development Program* 27
- *Evaluating a District's Proposed Curriculum for HIV Education* 43

Introduction

After an educational evaluation has been completed—the study designed, the data gathered, and the data analysis concluded—its results must be communicated to relevant decision makers. This booklet provides a set of five guidelines that will be useful to evaluators in preparing their reports. Also included are three sample reports that focus on different aspects of HIV education. Although these reports deal with the kinds of evaluative tasks evaluators of HIV education programs often face, all three are fictitious. They are not intended to describe "exemplary" evaluation studies but are included here to illustrate the five guidelines and to provide options for reporting the results of HIV education evaluation studies. Evaluators of HIV education should select only those segments of the reports that seem suitable to their particular studies of HIV education.

Five Report Preparation Guidelines

Based on the experiences of educational evaluators for well over two decades, the following five guidelines have been identified to assist you in your reporting efforts. Some of these reporting guidelines may be more relevant to you than others.

Guideline 1: Evaluation reports should be decision focused.

Maintain a decision focus.

Educational evaluation activities should provide information that will help program planners make better decisions. If your evaluation study deals chiefly with decisions to improve the program, then the report should be structured so that the relevance of your findings to those decisions is clear. For program-improvement evaluations, decision makers will typically be the HIV education program's instructional staff. If the evaluation study deals dominantly with a decision to continue or discontinue a program, then the report should be organized so that the decision makers will understand how the report's findings bear on their decision. For program-continuation evaluations, decision makers are likely to be school board, administrative, and grant agency personnel.

Evaluation reports are organized around fairly conventional sections. Two slightly different organizational structures are presented below:

Commonly Used Sections of Evaluation Reports

Style 1	Style 2
• Introduction	• The Setting
• Procedures	• Decisions at Issue
• Assessment Instruments	• Program Description
• Data Analysis	• Outcome Variables
• Results	• Procedures
• Discussion	• Findings
• Recommendations	• Discussion

Although a well-designed evaluation will be conducted to provide decision-relevant information to those making decisions about the program, an evaluator is sometimes tempted to include all of the data collected. However, an evaluation report should be concise and focused only on program-relevant decisions.

Guideline 2: Evaluation reports should be as brief as possible.

This second guideline is really a corollary to the first guideline's focus on decisions. Regardless of whether you're providing a report on a program-continuation evaluation to a school district's governing board or a report on a program-improvement evaluation to health educators staffing an HIV education program, the recipients of your evaluation report are bound to be busy people. To get your report read and used, you'll typically have to make it brief enough so that a busy decision maker will be inclined to read it.

Keep reports brief.

Staff members of state or federal legislators usually suggest that when a document exceeds one or two pages in length, the likelihood of its being read drops. In evaluation reporting, *less* is truly *more*. Thus, succinct reporting should be your goal when preparing an evaluation report. Eliminate the extraneous information and get to the heart of things.

It is impossible to define "brief" in terms of the numbers of pages in an evaluation report. A 25-page evaluation report might be considered brief for a major year-long study of a state's HIV education program. For an evaluation of a one-hour schoolwide assembly dealing with HIV risks, however, a 25-page evaluation report would most likely be considered lengthy. Be guided by the magnitude of the evaluation study itself, then try to be as succinct as is sensible in that situation.

Guideline 3: At least two levels of detail should be provided in all evaluation reports.

Provide at least two levels of detail.

This guideline, aimed at increasing the likelihood that an evaluation report will be used, urges evaluators to always provide two or more degrees of descriptive detail. Suppose, for example, that in accordance with Guidelines 1 and 2 you have prepared a lean, decision-focused evaluation report of eight pages. Your report is, by most standards, quite brief. Even so, you should introduce it with an executive summary of one page or less. Such summaries cut to the core of the study by including only the most important highlights. Creating an accurate and readable executive summary is a challenge, but, because decision makers will often read *only* an evaluation report's executive summary, it is worthwhile. The three sample evaluation reports provided later in this booklet are introduced by an executive summary.

More substantial evaluation studies, such as a lengthy study of HIV-focused staff development provided by a state department of education over a two-year period, may need three levels of reporting: (1) the evaluation report itself, (2) a one-page or executive summary, and (3) a separate technical supplement that describes the procedures, data analysis, and results in more detail. The length of this supplement might run to 40 pages or more. The decision to prepare a separate technical supplement usually depends on the magnitude of the evaluation study and, even more importantly, on the likelihood that decision makers will truly require this information.

One of the dividends of separating technical information into its own supplement is that the evaluator avoids including the potentially deflective information in the evaluation report itself. The brevity and focus of the report is maintained and the likelihood that it will be read is increased. Thus, with some exceptions,

242

using one of the reporting plans described below will usually prove satisfactory for evaluators of HIV education programs:

Concise Reporting	**Customary Reporting**	**Complete Reporting**
• A 1-2 page report	• An executive summary	• An executive summary
	• A brief report	• A brief report
		• A technical supplement

Clearly, the purpose of multilevel reporting is to increase the probability that decision makers will attend to the results of your evaluation study.

Guideline 4: Evaluation reports should be as readable as possible.

One important way to strengthen the likelihood of your report's being read is to make it readable. Decision makers are less likely to read a dense, stiffly written 10-page document with no figures, tables, or white space than a well-written 10-page document that features attractive headings, reasonable white space, and several key tables and figures.

Keep it readable.

When you prepare your evaluation report, write directly to your particular audience. Use a writing style and a vocabulary that are at the same level as your audience's reading abilities, dispositions, and interests. Keep the writing direct and simple, and avoid complex terminology. You might want to hire a good editor who can help make the report easier to read and understand.

Use graphics and tables whenever possible. Many people will grasp your point more quickly by studying a well-conceived graphic than by reading a written explanation of the same information.

Use a variety of headings and subheadings to help the reader follow the report's sequence and see what's coming. Use white space along with the headings to break up the negative visual impact of an unending set of paragraphs. For lengthier reports, be sure to use a table of contents. In short, make the report visually appealing.

The essence of Guideline 4 is to increase the readability of an evaluation report so that it will actually be read. There are too many instances of important evaluation studies that never made an impact because the evaluators created documents that were uninviting to the reader.

Guideline 5: Offer to provide an oral report about the study.

Not all decision makers learn best from written reports; many prefer and will be more effectively informed by an oral presentation. An oral report will provide an opportunity for a question-and-answer period that can prove particularly illuminating to the decision makers.

Prepare an oral presentation.

If your offer to provide a supplementary oral report is accepted, you will need to prepare it with great care. Your oral report should incorporate each of the previous guidelines: (1) keep your remarks decision focused, (2) cut your presentation to the bone and practice it to make sure that it can be delivered well within your allotted time, (3) begin with a succinct oral "executive summary" of the report's results, and (4) enhance the visual appeal of your report through visual aids and a well-structured oral presentation.

Conclusion

The chief purpose of reporting results of HIV education evaluation studies is to present relevant information to those who must make decisions about the program involved. For the study's information to be used, however, it must be effectively communicated to decision makers. The art of effective evaluation reporting is thus the art of effective communicating.

Three Sample Evaluation Reports

The following three sample evaluation reports exemplify the five guidelines. Because they are only examples, some of these reports are shorter than they might be in a real situation. Nonetheless, as suggested in Guideline 2, brevity in reporting is a desirable attribute. Each of the three reports is introduced by a short description to set it in context.

The reports included here should not be considered prescriptive in any sense; rather, they contain different ways of reporting evaluation studies to those who will use the results. The first report describes an evaluation of a district-level HIV program's impact on students. The second report deals with a state department of education's staff-development activities on HIV. The third report evaluates a proposed new HIV education curriculum prior to its installation in a school district.

In the three sample reports, you'll see several different kinds of page layouts that are available to users of personal computer word-processing programs. Organize what's on a page so that it will entice the reader. Look to examples beyond those supplied in this booklet to get more ideas about what to put in your evaluation reports.

Sample Report Number One: Evaluating a District HIV/AIDS Education Program

This report summarizes the findings from an evaluation of a new HIV/AIDS prevention program in a fictitious school system. The "Metro City School District" was the site of an evaluation of a state-of-the-art, 15-hour program that was offered during required tenth grade social studies classes.

The Metro City School District is quite large (20 high schools with an average enrollment of 1,500 students) and has a five-member Research and Evaluation Office. At the request of the Board of Education, the district superintendent directed the Research and Evaluation Office staff to introduce a sound, theory-based, and tested HIV/AIDS prevention program into all district high schools. The first step in this process involved evaluating the effectiveness of the selected program with a sample of the district's high school students.

The following report was prepared at the conclusion of the evaluation study by the Research and Evaluation Office. In a memorandum accompanying the report, members of the office offered to make a supplementary oral report to the superintendent and/or the board of education.

Effectiveness of the Metro City School District HIV/AIDS Prevention Program

A Report to the Superintendent

by the
Research and Evaluation Office
Metro City School District

July 1991

247

TABLE OF CONTENTS

Page

EXECUTIVE SUMMARY iii

INTRODUCTION 1

  The HIV/AIDS Prevention Program 1

METHOD 1

ASSESSMENT INSTRUMENTS 2

RESULTS 2

  Demographics 3

  Knowledge 3

  Confidence in Resisting Peer Pressure 5

  HIV-Risk Behaviors 6

  Delivery of the HIV/AIDS Prevention Program 8

DISCUSSION AND RECOMMENDATIONS 8

  Conclusions 8

  Recommendations 8

EXECUTIVE SUMMARY

During the 1990-91 academic year, the Research and Evaluation Office conducted an evaluation of a state-of-the-art HIV/AIDS education program, prior to adopting it for districtwide implementation. Twelve schools were randomly selected to take part in the study, and half of these were randomly assigned to treatment. The curriculum was offered during required tenth grade social studies classes. No differences were found at pretest between the treatment and control groups. At posttest, however, the curriculum had a significant impact on students' certainty in their correctly held HIV-knowledge and confidence in their ability to resist HIV-related peer pressure. Further, the curriculum had a positive impact on reported HIV risk-behaviors; significantly more sexually abstinent students at posttest continued to refrain from sexual intercourse in the treatment group than in the control group, and significantly more sexually active students used condoms at last intercourse in the treatment than in the control group. It is strongly recommended that the HIV/AIDS Prevention Program (HAPP) be implemented as soon as possible in tenth grade social studies classes throughout the district. Three additional recommendations are included which could make this program even more effective: (1) provide support for teachers who have questions or concerns during intervention implementation, (2) provide, in other areas of the high school curricula, enhanced skill-building opportunities for students to resist peer pressure to engage in risky behaviors, and (3) increase emphasis on the debilitating effects of alcohol and drug use which impair judgment and increase the likelihood of participation in high-risk behaviors.

INTRODUCTION

During the 1990-91 academic year, a new 15-hour HIV/AIDS Prevention Program (HAPP) was evaluated in a randomly selected group of tenth grade classes in the Metro City School District (MCSD). The curriculum was offered during required social studies classes. To account for maturation effects, control classes were included in the study design. A decision will soon be made whether to install the curriculum districtwide for the 1991-92 academic year. This report describes the evaluation, presents the results, and provides recommendations regarding use of the curriculum.

The HIV/AIDS Prevention Program

The new curriculum is a state-of-the-art, 15-hour program designed to provide students with the functional knowledge, attitudes, and interpersonal skills necessary to help them avoid HIV-risk situations. HAPP provides numerous opportunities for students to practice interpersonal and refusal skills during structured role-play situations.

METHOD

A two-group (treatment versus control) design was employed to evaluate HAPP. All 20 of the district's high schools were willing to participate in the study. To meet sample size requirements, it was decided that a random sample of six treatment schools and six control schools would be included in the study, and that two classes from each school would be used. Because schools varied in their demographic characteristics, 10 matched pairs were formed based on location, size, and racial/ethnic composition. Six pairs of schools were randomly selected by drawing from a hat containing the 10 paired names. One school from each pair was assigned to the treatment condition and the other to the control condition by the flip of a coin. Two tenth grade social studies classes were randomly selected at each participating school. Thus, within the experimental group 12 classes received HAPP, and within the control group 12 classes received the typical social studies curriculum. In all, 622 students took part in the study.

All 12 tenth grade social studies teachers in the treatment schools took part in a five-day staff development session during August 1990. An evaluation report on the quality of the teacher training is on file in the district office.

An important aspect of the evaluation study involved examining the degree to which MCSD tenth grade social studies teachers in the treatment classes properly implemented HAPP. A brief questionnaire was distributed to teachers in the treatment classes which focused on (1) the degree to which each of the lessons was taught as planned, (2) any unforeseen issues or problems that arose, and (3) the teacher's confidence in teaching the material.

ASSESSMENT INSTRUMENTS

Three assessment instruments were used to pretest and posttest all students in both the treatment and the control classes. Students received the instruments prior to curriculum implementation and three months following implementation. All three instruments were drawn from a collection of measuring devices distributed by the Centers for Disease Control (CDC)[*]. Copies of all three instruments are available in the MCSD Research and Evaluation Office.

> *Knowledge of HIV and AIDS.* This 15-item inventory is available in two equivalent forms. Form A was used as the pretest and Form B was used as the posttest.
>
> *How Confident Are You?* This 10-item instrument assesses students' confidence in their ability to resist peer pressure. Five of the instrument's items deal with the kinds of pressures associated with HIV-risk behaviors.
>
> *Your Behavior.* This 5-item inventory was abbreviated from a longer instrument distributed by CDC. Five questions focusing on students' HIV-related behaviors were selected for the version of the instrument used in this evaluation. Students' responses to these questions are recorded in a way that ensures anonymity.

In addition to these instruments, all teachers in the treatment condition completed questionnaires, as previously described, to examine whether the curriculum was implemented as planned and to help identify barriers to successful implementation.

RESULTS

All students in both the treatment and control classes completed the three assessment instruments in September 1990 and again in April 1991. Following the pretest, treatment and control students were described demographically. Chi-square tests for categorical data were used to determine whether the randomly selected groups were statistically different.

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[*] Centers for Disease Control, Division of Adolescent and School Health, *Assessment Instruments for Measuring Student Outcomes: Grades 7-12*, Atlanta, Georgia, 1992.

Chi-square tests and *t*-tests were also used to examine whether students in the treatment group differed significantly from those in the control group on the basis of pretest scores.

Finally, treatment and control groups were compared on their posttest scores in the areas of knowledge, confidence in resisting peer pressure, and HIV-related behaviors. Results from these analyses are provided below.

Demographics

Demographic characteristics considered important in this study were school location (urban versus suburban), school size, student gender, and student race/ethnicity. Chi-square tests were performed to determine whether the treatment and control groups were significantly different on any of these features. As shown in Table 1, groups were similar on all relevant characteristics.

Knowledge

Students were asked to respond to a series of 15 statements by indicating for each statement either "I am sure it's true," "I think it's true," ""I don't know," "I think it's false," or "I am sure it's false." The instrument was scored in two ways. First, students' responses were considered correct or incorrect according to whether they accurately identified statements as true or false. These knowledge-only scores can range from a low of 0 to a high of 15. Second, students' certainty in correctly held knowledge was calculated for each item using a 5-point scale. Total certainty scores can range from a low of 15 to a high of 75. In Figure 1, these two scores are presented as the percentage of possible points that can be earned. Thus, if a student earned 12 of 15 possible knowledge points, that student was given a knowledge "percent possible" score of 80. If that same student earned 45 of 75 possible certainty points, the student would receive a certainty "percent possible" score of 60.

At pretest, no significant differences were shown between the treatment and control groups on knowledge-only scores or on the certainty-in-knowledge scores. Because the treatment and control groups were comparable at pretest, posttest scores were used to examine the effects of the curriculum.

Table 1.
Demographic Distributions
by Treatment and Control Conditions

	Treatment	Control	Chi-square
School Location			
Urban	66%	59%	
Suburban	33%	41%	3.234
School Size			
<1,000 students	36%	42%	
>1,000 students	64%	58%	2.284
Gender			
Male	49%	49%	
Female	51%	51%	-----*
Ethnicity			
Asian	10%	6%	
Black	36%	33%	
Hispanic	18%	22%	
White	32%	33%	
Other	4%	6%	1.476

* With identical data, statistical tests could not be computed.

At posttest, differences between the treatment and control students were not statistically significant for the knowledge-only scores. However, a statistical difference was found between the groups on the certainty-in-knowledge scores ($t = 3.527$, d.f. = 598, p. = 0.002). Figure 1 shows the percent possible posttest scores for treatment and control groups on the knowledge-only and certainty-in-knowledge measures.

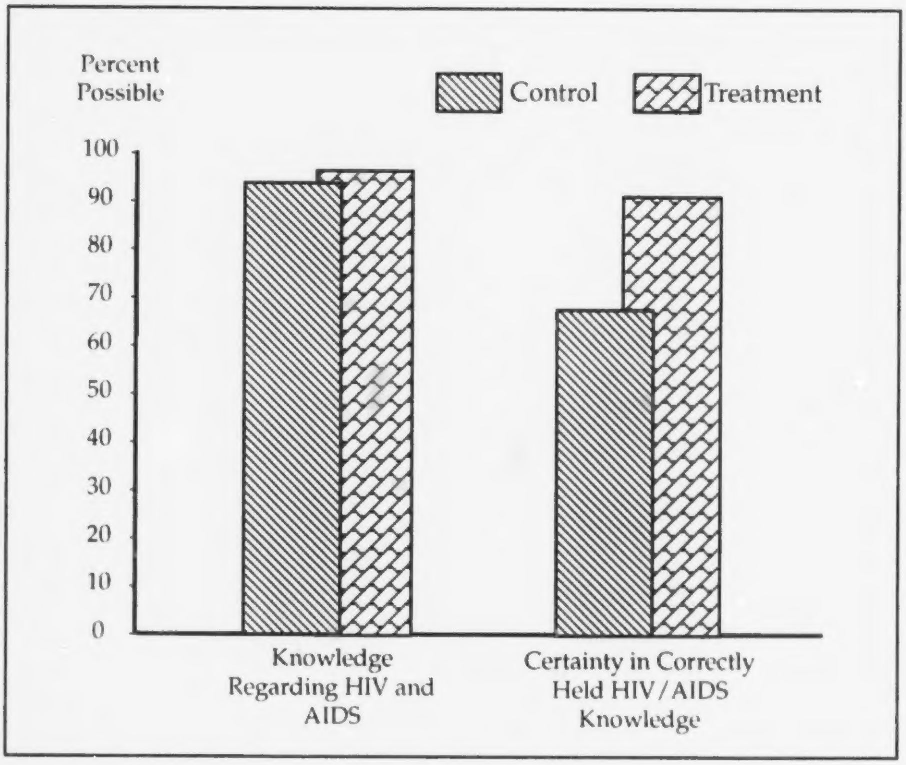

Figure 1. Mean posttest performance for treatment and control groups on knowledge items

Confidence in Resisting Peer Pressure

On this measure, students respond to 10 vignettes dealing with peer-pressure situations by indicating their degree of confidence in avoiding risk behaviors. Items are scored on a 5-point scale from "Completely Confident" to "Not at all Confident." Total scores can range from 10 to 50. In addition to the total score, two 5-item subscores were formed, one to examine general peer pressure and one to examine peer pressure specific to HIV-risk behaviors. Each subscore can range in value from 5 to 25.

At pretest, no significant differences were shown between the treatment and control groups on their total confidence scores or on either of the two subscores.

At posttest, statistical differences were found between the treatment and control groups in their overall confidence (*t* = 5.846, d.f. = 598, p. = 0.0001). While no differences were found on the general peer pressure subscale, treatment students showed greater confidence than control students in the area of HIV-risk-related peer pressure (*t* = 8.624, d.f. = 598, p. = 0.00001). Posttest results are presented graphically in Figure 2.

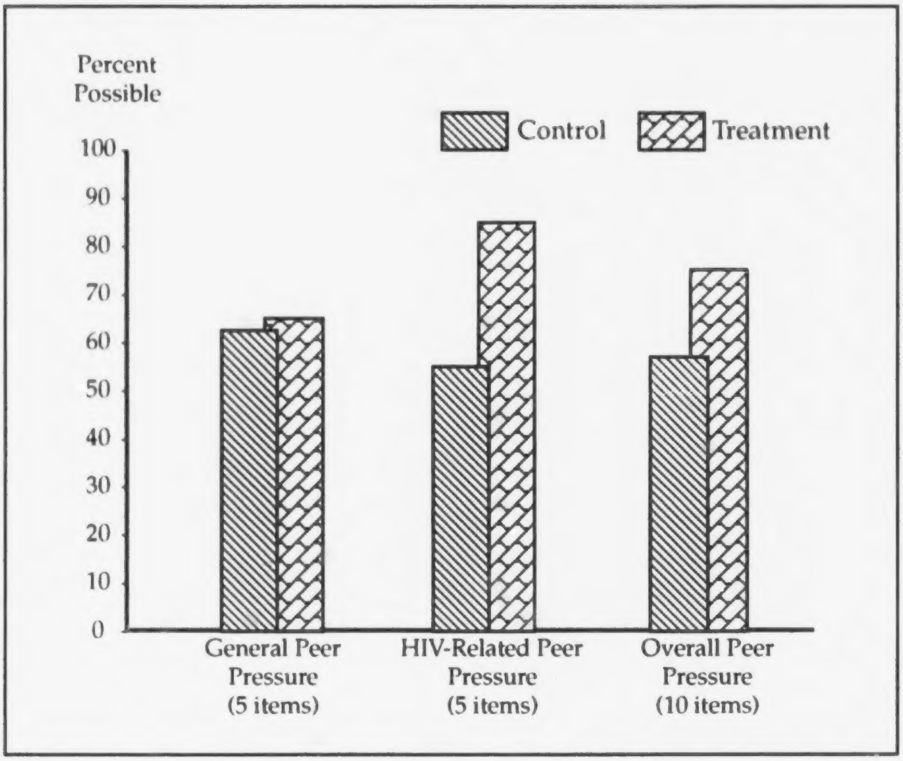

Figure 2. Mean posttest performance for treatment and control groups on confidence in resisting general and HIV-related peer pressure

HIV-Risk Behaviors

The five behavior items shown in Table 2 were used to examine differences among treatment and control students at pretest and posttest. No significant differences were shown between the two groups on any of the behavior items at pretest. However, at posttest, some significant differences were noted.

Table 2.
Mean Posttest Responses for Treatment
and Control Groups on HIV-Risk Behaviors

				Chi-Square
All Students:				
Have you ever had sexual intercourse?				
Control	n = 322	No = 42%	Yes = 58%	
Treatment	n = 300	No = 55%	Yes = 45%	10.622*
Have you injected drugs during the past 30 days?				
Control	n = 322	No = 96%	Yes = 4%	
Treatment	n = 300	No = 98%	Yes = 2%	0.651
Students who were sexually active at posttest:				
The last time you had sex, did you use a condom?				
Control	n = 187	No = 65%	Yes = 35%	
Treatment	n = 135	No = 42%	Yes = 58%	16.774*
During the past 30 days, with how many persons have you had sex?				
Control	n = 187	None = 35%		
		1 = 48%		
		2 = 13%		
		3 or more = 4%		
Treatment	n = 135	None = 37%		
		1 = 51%		
		2 = 7%		
		3 or more = 3%		2.860
The last time you had sex, did you drink alcohol or use drugs?				
Control	n = 187	No = 69%	Yes = 31%	
Treatment	n = 135	No = 72%	Yes = 28%	0.603

* $p<0.01$

At posttest, a significantly greater proportion of treatment students continued to refrain from sexual intercourse than control students. Specifically, 55 percent of treatment students had not initiated intercourse at the time of the posttest, compared to 42 percent of control students. A separate analysis was conducted for students who reported having been sexually active during their lifetime. Among this group, significantly more treatment students (58 percent) than control students (35 percent) reported condom use at last intercourse. No differences between groups were found for sexually active students in reported number of sexual partners during the past 30 days or use of alcohol or drugs at last intercourse. Finally, no differences were shown between treatment and control groups in injected drug use during the past 30 days.

Delivery of the HIV/AIDS Prevention Program

Teachers' responses to the implementation questionnaire indicate that HAPP lessons were presented essentially as they were designed. One of the teachers indicated that it was impossible to complete the curriculum in the time allotted, and two indicated serious concerns about their ability to adequately address sensitive issues. These three respondents noted that it would have been helpful to have someone to consult with during the intervention period.

DISCUSSION AND RECOMMENDATIONS

Conclusions

HAPP has been found to be successful in increasing students' certainty in their correct knowledge about HIV/AIDS and confidence in resisting HIV-related peer pressure. The curriculum also showed a positive impact on students' HIV-related behavior including (1) delay of sexual intercourse by students who were not sexually active at the pretest, and (2) increased condom use at last intercourse for sexually active students.

No significant differences were found between treatment and control groups in knowledge-only scores. This can be attributed, in part, to the fact that both groups had quite high knowledge scores at pretest. No significant differences were found in confidence in resisting general peer pressure, in the number of sexual partners in the past 30 days, or in alcohol or drug use at last intercourse. Finally, no significant differences were found in injected drug use during the past 30 days. This finding is not surprising given that very few students in either the treatment or control group were involved in injecting drugs.

Recommendations

It is recommended that HAPP be implemented as soon as possible in tenth grade social studies classes throughout the district. Three additional recommendations are provided that may help to make this program even more effective:

> ***Recommendation 1:*** *Provide support for teachers who have questions or concerns during intervention delivery.*
>
> ***Recommendation 2:*** *Provide, across a range of subject areas, skill-building opportunities for students to resist general peer pressure to engage in risk behaviors.*

Recommendation 3: *Increase emphasis on the debilitating effects of alcohol and drug use because they impair judgment and increase the likelihood of participation in risk behaviors.*

Sample Report Number Two: Evaluating a State HIV Staff Development Program

This second report appraises a fictitious statewide staff development program for 500 teachers who will be responsible for providing HIV education in their school districts.

The "State X" Board of Education has a standing policy that major new educational programs in the state be subjected to a two-stage evaluation process. First, an improvement-focused evaluation is to be conducted. After several years, a continuation-focused evaluation is to be carried out to help decide whether the program should remain in existence. The following report describes the improvement-focused evaluation of ten two-day workshop sessions intended to provide State X's teachers with the skills and knowledge needed to effectively teach an HIV education program.

An Evaluation of the HIV Staff Development Workshop Provided by the State X Department of Education

A Report to the State X Board of Education

by the
Evaluation Division
of the
State X Department of Education

January 1992

TABLE OF CONTENTS

EXECUTIVE SUMMARY iii

INTRODUCTION 1

- The HIV/AIDS Education Workshop 1
- Workshop Particulars 1
- An Improvement Focus 2

METHOD 2

- Outcome Variables 2
- Procedures 3
- Data Analysis 3

FINDINGS 4

- The Four CDC Instruments 4
- The Workshop Evaluation Sheet 5
- Staff Interviews 5

DISCUSSION 6

RECOMMENDATIONS 6

EXECUTIVE SUMMARY

The Evaluation Division conducted an improvement-focused evaluation of ten 1991 statewide sessions of the HIV/AIDS Education Workshop. Before and after the two-day sessions, a total of nearly 500 teachers completed four evaluation instruments. An analysis of the results indicated that the workshop substantially increased teachers' knowledge about HIV and their confidence regarding the teaching of HIV-related topics. Little or no improvement was seen, however, in teachers' comfort in discussing sensitive topics or in their acceptance of people with AIDS/HIV. On a separate postworkshop evaluation sheet, participants gave the workshop an overall grade of B+ and offered several suggestions to improve it. During in-person interviews, the workshop's five-member instructional team also offered constructive criticism.

The Evaluation Division recommends that (1) the segment on sensitive topics be revised after members of the instructional staff receive formal instruction on that topic, (2) more systematic instruction be devoted to improving participants' attitudes toward persons who have HIV/AIDS, (3) experienced peer educators take part in the peer-education segment of the workshop, (4) trainers be reduced from five to two, and (5) an additional year of improvement-focused evaluation be followed by an evaluation to see if the workshop should continue to be offered.

INTRODUCTION

This report was prepared by the Evaluation Division of the State X Department of Education (SDE) in keeping with established policies of the State X Board of Education. The report describes a study designed to evaluate a series of SDE-sponsored workshops for teachers charged with delivering HIV education in their school districts. The evaluation study was formatively oriented—that is, intended chiefly to improve the quality of the workshops in anticipation of their being offered in subsequent years by SDE to other teachers. Accordingly, although the report is officially being submitted to the state board, an important audience for the report is the five-person SDE team that designed and offered the workshops.

The HIV/AIDS Education Workshop

The HIV/AIDS Education Workshop is a two-day session developed during late 1990 and early 1991 by a five-member team from the SDE Health and Guidance Division. In planning the content of the workshop, the SDE staff relied heavily on a needs-assessment survey that SDE had sent in early 1990 to a representative sample of 200 teachers in the state. The workshop was offered for the first time during late September and October of 1991 at ten geographically dispersed sites throughout the state. The workshops were offered either on a Monday-Tuesday or a Thursday-Friday. School districts near the workshop sites were invited to send a specified number of teachers (2-10), depending on the size of the district. Approximately 50 teachers attended each two-day workshop. The workshop instructors were the five SDE staff members originally responsible for creating the workshop.

Workshop Particulars

Each of the two workshop days lasts from 8:30 am until 4:30 pm. The agenda for each of the two days is provided below. Brief recesses are taken throughout each day.

Day One

Time	Topic
8:30 - 9:00	Pretest, Introductions, Workshop Overview
9:00 - 10:30	Essential Information about HIV and AIDS
10:30 - 12:00	Students' HIV-Risk Behaviors and How to Alter Them
1:00 - 2:30	Promoting Students' Realistic Risk Perceptions
2:30 - 3:30	How to Discuss Sensitive Topics
3:30 - 4:30	The Role of Peer Educators

263

Day Two

Time	Topic
8:30 - 9:30	The Role of Interpersonal Skills in Reducing HIV Risk
9:30 - 12:00	How to Teach HIV-Related Interpersonal Skills
1:00 - 2:30	Providing Students with Generalizable Practice in Using Interpersonal Skills
2:30 - 3:30	Promoting Appropriate HIV-Related Attitudes
3:30 - 4:15	Evaluating Your Own HIV-Related Teaching
4:15 - 4:30	Posttest, Workshop Evaluation, Adjournment

An Improvement Focus

The evaluation study was designed to supply information that would result in the improvement of the HIV/AIDS Education Workshop. This report concludes with a series of specific suggestions for improving the two-day workshop sessions.

METHOD

Outcome Variables

Five assessment instruments were used in the evaluation study. Four of these were supplied by the Division of Adolescent and School Health of the Centers for Disease Control (CDC) in Atlanta, Georgia. The fifth instrument was a workshop-specific evaluation form. Each of these five instruments is briefly described below.

Knowledge. *Knowledge of HIV and AIDS* is a 25-item true-false inventory. It yields a number-correct score (ranging from a low of zero to a high of 25).

Instructional Confidence. *Instructional Confidence* is a 10-item inventory. Scores can range from a low of 10 to a high of 50.

Comfort in Discussing Sensitive Topics. *Comfort with Sensitive Topics* is a 10-item inventory measuring teachers' perceived ease in being able to talk about sensitive topics such as those associated with sexual practices or drug usage. Scores can range from a low of 10 to a high of 50.

Acceptance of People with HIV/AIDS. *Attitudes toward People with HIV or AIDS* is a 10-item inventory. Scores can range from a low of 10 (reflecting lesser acceptance of such individuals) to a high of 50 (reflecting greater acceptance of such individuals).

Workshop Evaluation Sheet. At the close of the two-day session, workshop participants were asked to anonymously complete this brief evaluation form. The three most important questions on the sheet asked participants to (1) assign a grade (A, B, C, D, or F) to the workshop, (2) describe the features of the workshop that should remain unchanged, and (3) describe the features of the workshop that should be modified.

Procedures

The evaluation used a modified pretest-posttest design. To conserve instructional time, workshop participants completed as a pretest either (1) the 25-item knowledge test or (2) the three 10-item inventories measuring instructional confidence, comfort in discussing sensitive topics, and acceptance of people with HIV/AIDS. As a posttest, participants completed the instrument(s) they had not completed as a pretest. All participants filled out the Workshop Evaluation Sheet at the end of the workshop.

In this type of item-sampling scheme, the mean performance of approximately half of the participants in any given workshop (for both pretest and posttest) represented the total group. In all, for the 10 sessions of the workshop, 496 teachers supplied pretest data and 478 teachers supplied posttest data.

In addition, separate half-hour interviews with each of the five workshop instructors were carried out by members of the SDE Evaluation Division during December 1991. The comments of the instructors figured into the recommendations that conclude this report.

Data Analysis

For the first four outcome variables—that is, all instruments but the Workshop Evaluation Sheet—an overall pretest mean and an overall posttest mean were computed from pretest and posttest means from each of the 10 workshop sessions. For ease of reporting, each of these overall means was transformed into a percentage of attainable points. In other words, if an instrument's highest possible score was 50 points, and the pretest mean for that instrument was 30 points, this pretest result was reported as 60 percent of the points potentially attainable on the instrument. Pretest and posttest percentages were then compared for each of the four outcome variables.

For the Workshop Evaluation Sheet, a simple summary of per-item responses was prepared. The mean overall grade assigned by participants was also computed.

FINDINGS

The Four CDC Instruments

As can be seen in Figure 1, participants made substantial pretest-to-posttest gains in their knowledge about HIV/AIDS (pretest: 65%, posttest: 93%) and in their confidence about teaching their students about HIV and AIDS (pretest: 59%, posttest: 78%). On the other hand,

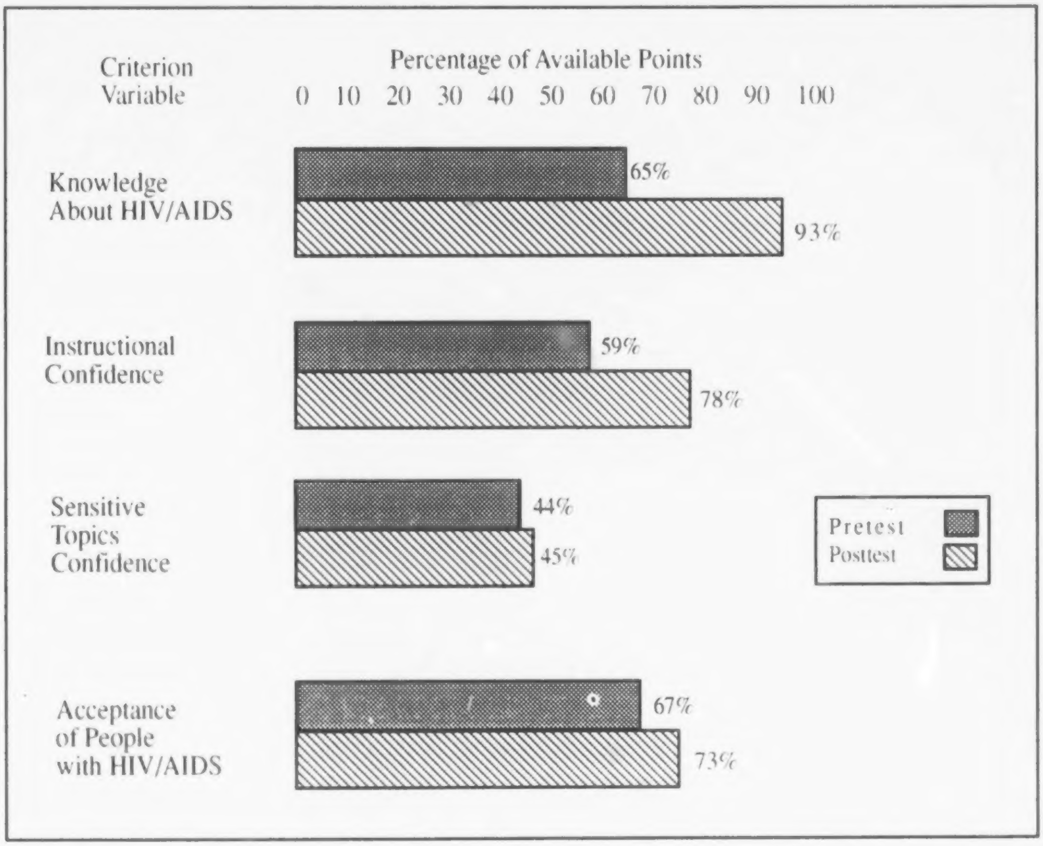

Figure 1. Overall pretest and posttest mean performances of workshop participants on four assessment instruments used in the evaluation study.

participants gained essentially no confidence in discussing sensitive topics (pretest: 44%, posttest: 45%). Although participants became somewhat more accepting of persons who have AIDS or who are infected with HIV, this gain was modest (pretest: 67%, posttest: 73%).

The Workshop Evaluation Sheet

An average grade of B+ was assigned to the workshop by the 476 teachers who responded to that item on the Workshop Evaluation Sheet. Three aspects of the workshop were endorsed by more than half of the respondents (the percentage of respondents supplying each of the reactions is given in parentheses):

- the second-day emphases on interpersonal skills (63%)
- the small number of workshop participants and the instructional staff's use of subgroup activities (58%)
- the first-day session dealing with how to promote more realistic HIV-risk perceptions among students (52%).

These reactions were *generated* by participants (as opposed to being *selected* from options on the Workshop Evaluation Sheet).

Two suggestions for improvement were cited by more than 50 percent of the participants. Sixty-four percent of the participants called for a complete revision of the one-hour segment dealing with the discussion of sensitive topics. Almost two-thirds of the participants believed that the trainers were embarrassed by the discussion of these sensitive topics. Fifty-seven percent of the participants believed that the segment dealing with peer educators was ineffective; many of these participants suggested that students who had served as peer educators should take part in this segment of the workshop.

Staff Interviews

The half-hour interviews with each of the five members of the instructional team indicated that the staff adheres quite closely to the lesson plans originally devised for the workshop. Three of the five staff members believed that the session could be effectively staffed by only two instructors per workshop; tying up five staff members for the early part of a school year seemed unwarranted to them. All of the instructors sensed that their treatment of sensitive topics was inadequate, but they were unable to suggest specific solutions. Four of the five instructors were particularly pleased with the workshop's strong emphasis on interpersonal skills. All five instructors thought that the session dealing with the promotion of more realistic HIV-risk perceptions among students was highly effective.

DISCUSSION

Overall, the HIV/AIDS Education Workshop appears to prepare the state's teachers to deliver HIV education effectively. The teachers who took part in the evaluation were generally positive about the workshop and made meaningful pretest-to-posttest gains in their knowledge about HIV/AIDS and in their confidence in teaching their students about HIV/AIDS.

Given that the workshop has only been offered one time statewide, it is not surprising that the workshop can be improved and made even more effective.

RECOMMENDATIONS

1. *After the instructional staff is trained to discuss sensitive topics more comfortably, that segment of the workshop should be significantly revised.*

   Rationale: An analysis of several data sources suggests that this segment of the workshop is weaker than it should be. The instructional staff will apparently benefit from outside training in this area. Following the training, this segment should be altered to provide participants with first-hand experience in dealing with sensitive topics.

2. *More instructional attention should be given to participants' acceptance of people who have AIDS or who are infected with HIV.*

   Rationale: Currently, this topic seems to receive no formal instructional attention. Most of the trainers appeared to believe that participants would naturally become more accepting of people with AIDS/HIV during the workshop. Attitudinal modification, however, typically requires a systematic and sometimes sustained instructional effort. Consultation with an attitudinal education specialist may help improve this aspect of the workshop.

3. *Experienced peer educators should take part in the peer educator session (if retained).*

   Rationale: Many participants believed that the omission of peer educators weakened this segment of the workshop. The board should carefully consider including the appropriate students in this segment.

4. *The instructional staff for any workshop should be reduced from five to two instructors.*

   Rationale: By reducing the size of the instructional staff, future workshops can be more cost-effective without diminishing the instructional quality. Moreover, by rotating their instructional responsibilities for different workshops, the five SDE staff members will be able to devote themselves to other departmental responsibilities.

5. *An additional year of program-improvement evaluation should take place during the 1992-93 school year followed by a program-continuation evaluation in 1993-94.*

   Rationale: Based on this year's evaluation of the workshop, the instructional staff at the workshop should be able to make improvements to the workshop during the 1992-93 year. Another year of program-improvement evaluation should reveal any other needed improvement. After that, an evaluation directed to the State X Board of Education to determine whether to continue the workshop program should take place during the 1993-94 year.

Sample Report Number Three: Evaluating a District's Proposed Curriculum for HIV Education

The following sample report focuses on the curriculum of a recently developed HIV education program in the "Richfield County Schools," a fictitious midsize rural school district. The district's health educators and curriculum specialists have worked hard to create the new program, meeting twice a month for more than a year. The bulk of the new program is to be provided as a special two-week instructional unit near the middle of a one-semester health education course currently required of tenth grade students. In addition, a two-day knowledge-focused unit dealing with HIV is to be provided to the district's seventh grade students as part of their required physical education course.

Because this new HIV education curriculum represents a substantial increase in the number of instructional hours devoted by the district to HIV, the district's school board members unanimously agreed to a resolution requesting the district superintendent to secure an independent evaluation of the new curriculum ***before*** *installing it on a districtwide basis. Several board members, although recognizing the importance of expanded HIV-related instruction in district schools, expressed some reservations about the content of the new curriculum.*

The district superintendent contracted two professors from a nearby state university to carry out the curriculum evaluation. Both professors reviewed the written materials associated with the new program and conducted a lengthy question-and-answer session with the ten-person planning committee that created the curriculum. Several follow-up interviews with key members of the committee were also conducted by one or both of the professors. The report on the following pages was submitted to the superintendent, on schedule, six weeks after the two professors were contracted.

An Evaluation of the Proposed HIV Education Curriculum of the Richfield County Schools

A Report to the
Richfield County Schools
Board of Education

by
Maria A. Rodriguez
and
Steven E. Brown
College of Education
Brookhurst State University

May 1991

TABLE OF CONTENTS

Page

SYNOPSIS 1

INTRODUCTION 3

APPRAISING THE CURRICULUM 4

- Instructional Quality 4
- Functional Knowledge 4
- Realistic Vulnerability Appraisals 5
- Suitable Affective Dispositions 5
- Interpersonal Skills 6
- Parent Involvement 6
- Adequate Duration 7
- Summing Up 7

RECOMMENDATIONS 8

SYNOPSIS

A proposed HIV curriculum for the Richfield County Schools was reviewed on the basis of seven factors considered important in the quality of such programs. In essence, the curriculum was evaluated on the basis of its internal characteristics. On five of the seven criteria employed, the curriculum was considered strong. On one criterion the curriculum was judged average and on a final criterion the curriculum was judged to be weak. Six program-specific recommendations conclude the report.

INTRODUCTION

During the fall semester of 1989, health educators in the Richfield County Schools committed themselves to developing a new, more powerful instructional program to combat the rapidly expanding AIDS epidemic both in the state and, based on recent health statistics, in Richfield County. From November 1989 until January 1991, a districtwide committee met approximately twice a month to create a new HIV education curriculum for the district. Three of these meetings were also attended by a specially appointed advisory panel of non-educators including parents who assisted in the curriculum design. This new curriculum was presented by the committee to the district superintendent in January 1991 in a document entitled *HIV Education for the 1990s in Richfield County.*

During its February 1991 meeting, the Richfield County Board of Education requested that the proposed HIV education curriculum be evaluated prior to its installation in the county's schools. We were hired to supply such an evaluation.

The following two questions guided the evaluation of the proposed curriculum:

- *Should the proposed HIV education curriculum be adopted in the Richfield County Schools?*
- *If the curriculum is adopted, should it be installed as is or should it be modified?*

We organized our evaluation around a set of seven characteristics of appropriate HIV curricula for evaluating the effectiveness of an HIV education program. These characteristics are part of a set of guidelines distributed by the Centers for Disease Control in Atlanta, Georgia. We were also greatly aided by an extensive meeting with the planning committee that developed the new curriculum and by subsequent interviews with several committee members. We appreciate committee members' cooperation and candor.

The actual effectiveness of an HIV education program or, for that matter, any educational program, should be determined by the program's effects on students. Thus, if the proposed HIV education curriculum is adopted by the board, as proposed or with modifications, we strongly recommend that a systematic evaluation of the new program be carried out subsequently to ascertain its effects on the HIV-related behaviors of the students who receive the program.

The following curriculum review is based on the previously mentioned characteristics. We assume that readers of our report are familiar with the document describing the proposed curriculum (*HIV Education for the 1990s in Richfield County*).

APPRAISING THE CURRICULUM

Instructional Quality

This new curriculum, if it is to be successful, must be consistent with what is currently known about effective instruction. It is our view that the day-by-day series of lesson plans (provided in the descriptive materials accompanying the proposed curriculum) are remarkably consonant with current conceptions of effective instruction. The instructional objectives for each lesson are clearly formulated in terms of students' postinstruction behavior, knowledge, attitudes, or skills. Moreover, students are told the general thrust of each lesson at that lesson's outset. Numerous attempts are made to use students' prior relevant knowledge as a springboard for new concepts. The nature of explanations is generally clear and likely to be understood by tenth graders. Modeling—both by teachers and students—is effectively used throughout the lessons. Finally, frequent time is provided for student practice and is likely to be sufficient for the objectives involved. Overall, then, we regard the proposed HIV education program to be exemplary in its adherence to proven principles of instructional psychology. Although a proposed curriculum's impact on students cannot be predicted with any certainty, we believe that the new program is likely to be quite effective.

Functional Knowledge

An appropriate HIV education curriculum should provide information to students so that they gain the knowledge needed to avoid or reduce their risk of becoming infected with HIV. This knowledge is referred to as functional knowledge because it is likely to influence those student behaviors that are associated with HIV infection. In contrast to functional knowledge, we can think of HIV general knowledge as less personally relevant topics, such as how HIV was discovered or how severe the current HIV epidemic is in various parts of the world. An HIV education program likely to alter students' out-of-school behaviors emphasizes functional rather than general knowledge about HIV.

We found the tenth grade lessons to be solidly focused on functional knowledge, particularly the early lessons in the two-week unit, where there is an emphasis on HIV/AIDS information. The two seventh grade lessons, however, dealt far more with general than with functional HIV knowledge.

We believe that there should be a greater stress on functional HIV knowledge in the two seventh grade lessons. We should provide our young people with the information they need to protect themselves. We urge the planning committee to increase the emphasis on HIV functional knowledge in the seventh grade lessons. Specifically, these lessons should provide more information about the behaviors students must adopt to reduce their risk of HIV infection. The chief behaviors of this sort are sexual abstinence, use of condoms for those who are sexually active, and avoidance of drug injection and needle sharing in connection with drugs and steroids.

Realistic Vulnerability Appraisals

A well-conceived HIV education program should help students perceive more accurately their own vulnerability to HIV infection. The proposed curriculum is exceptionally strong in this regard, devoting three well-designed lessons (including two excellent videotapes) to helping students recognize their risk of HIV infection.

Suitable Affective Dispositions

A properly designed HIV education program should promote positive attitudes toward methods of avoiding HIV-risk behaviors. For example, sexual abstinence is the most effective way of avoiding HIV infection. Students should be encouraged to believe that it is desirable for them to be sexually abstinent. Similarly, students who are sexually active should be convinced of the need to use condoms. Students should also be convinced of the dangers of injected drug use and needle sharing.

In our view, the affective dimensions of the new curriculum have been underemphasized. Rarely can one identify explicit segments of the lesson plans, either for seventh grade or tenth grade lessons, that directly address the promotion of student affect. There are, for example, no instructional objectives dealing specifically with attitudes in any of the lesson plans—a possible indicator that county teachers are not familiar with methods for modifying students' attitudes. Achieving attitudinal changes in students requires careful planning and appropriately focused instructional sequences. We are aware of several HIV-focused instructional videotapes, widely used in the U.S., that deal directly with attitudes of viewers. Such videotapes should be reviewed for their relevance and likely effectiveness.

We believe that the tenth grade unit should give more attention to modifying student attitudes. Teachers involved in the tenth grade lessons and, if possible, those providing the seventh grade lessons will probably need training in affective instructional procedures.

Interpersonal Skills

The report of the planning committee, *HIV Education for the 1990s in Richfield County*, clearly stresses the importance of skill promotion as a vehicle for modifying teenagers' out-of-school health-related behaviors. The proposed curriculum emphasizes "refusal skills" and "social negotiation skills" during the two-week tenth grade unit. Although we believe students need more opportunities to practice their refusal skills, the planning committee is to be commended for the strong emphasis on interpersonal skills in the proposed curriculum.

The only exception we noted in an otherwise excellent instructional design deals with strengthening students' refusal skills, a topic addressed in the curriculum's second week. The amount of practice that students are given to sharpen their refusal skills is quite brief. As we understand current plans, a typical student actually practices his or her refusal skills for less than 30 minutes. Yet, members of the planning committee deem the promotion of refusal skills to be a particularly important aim of the new program.

Even if it means the addition of one or two more hours of instruction, we strongly recommend that students be given much more time to practice their refusal skills. Such refusal skills are vital to avoid HIV-risk behaviors. Sufficient practice in using refusal skills in response to varied forms of social pressure is clearly necessary.

Parent Involvement

A well-designed HIV education curriculum should provide concrete ways to involve parents/guardians in ensuring that their child avoids HIV infection. Parents/guardians can add substantially to the efforts of the school in encouraging their child to avoid HIV-risk behaviors. Because they are most concerned about the health and well-being of their child, parents/guardians are in the best position to discuss their values and expectations about the HIV education curriculum.

The proposed curriculum involves parents through homework assignments that correspond with the lessons. These assignments provide parents with information about HIV infection, as well as exercises to encourage parent-child communication about HIV prevention. We believe these homework assignments will help parents/guardians initiate HIV-related discussions with their child.

Adequate Duration

Effective HIV education programs ought to last long enough to achieve their objectives. The planning committee's proposal to expand the current tenth grade HIV curriculum from two hours to two weeks is clearly warranted.

We believe, based on our reading of relevant research studies, that high school seniors should receive a two- or three-hour "booster" session of HIV instruction. We urge the planning committee and the board to consider such supplemental instruction, perhaps offered in general assemblies for seniors or as part of required twelfth grade classes. In general, however, we thought that the duration of the instructional program was reasonable.

Summing Up

In review, using the seven CDC-supplied program characteristics, we arrived at the following curricular "report card" for the proposed HIV education program:

Criterion	Strong	Average	Weak
• Instructional Quality	✓		
• Functional Knowledge		✓	
• Realistic Vulnerability Appraisals	✓		
• Suitable Affective Dispositions			✓
• Interpersonal Skills	✓		
• Parent Involvement	✓		
• Adequate Duration	✓		

Overall, the proposed HIV education program is an exceptionally well-designed curriculum that appears to recognize not only current advances in health education and health knowledge but also sound thinking in the field of instructional psychology. We solidly support the proposed HIV education program.

RECOMMENDATIONS

To highlight the recommendations offered in the report, we have listed them separately below:

1. *The new HIV education curriculum should be adopted in Richfield County Schools and put to use as soon as possible.*
2. *Tenth grade students should have more opportunities to practice their refusal skills, even if this entails an extra two days of instruction.*
3. *Functional knowledge should be emphasized more than general knowledge in the seventh grade lessons.*
4. *More instructional time should be devoted to promoting appropriate HIV-related attitudes.*
5. *Participating teachers should be trained in affective instructional procedures.*
6. *The board should seriously consider adding a twelfth grade booster session of HIV instruction.*

In conclusion, we do not wish our recommendations to detract from what is a praiseworthy instructional design. The curriculum conceived by the planning committee addresses the HIV problem in Richfield County head on. The proposal should be accepted by the Richfield County Schools Board of Education.

HANDBOOK OVERVIEW

This booklet is part of a series of eight booklets included in the *Handbook for Evaluating HIV Education*. The handbook contains evaluation designs and measurement tools necessary to collect data on the basic program components of policy development, curriculum design, teacher training, and student outcomes. The eight booklets are listed below.

1. Evaluating HIV Education Programs
2. Developing and Revising HIV Policies
3. Appraising an HIV Curriculum
4. Evaluating HIV Staff Development Programs
5. Assessment Instruments for Measuring Student Outcomes: Grades 5-7
6. Assessment Instruments for Measuring Student Outcomes: Grades 7-12
7. Choosing and Using an External Evaluator
8. Reporting Results of HIV Education Evaluations

For further information on the use of these booklets, please contact your state HIV coordinator or your CDC project officer.